

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7948

## CERTIFICATE OF DEATH

Reg. Dist. No. 07940

|  |                           |   |                             |   |  |   |                                |
|--|---------------------------|---|-----------------------------|---|--|---|--------------------------------|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY<br>Frederick MARYLAND  |                           |   |                             | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institutional: Residence before admission)<br>a. STATE<br>Maryland b. COUNTY<br>Frederick |  |   |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Braddock Heights   |                           | c. LENGTH OF STAY IN 1b<br>13 years   |                             | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Braddock Heights  |  |   |                                |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                           |   |                             | d. STREET ADDRESS<br>Schley Ave.  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First Middle Last<br>Lucy Ellen Alder   |                           |   |                             | <b>4. DATE OF DEATH</b><br>Month Day Year<br>7 19 1961  |  |   |                                |
| 5. SEX<br>female   | 6. COLOR OR RACE<br>white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>unknown |   | 9. AGE (In years lost birthday)<br>93 yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>housewife   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>own home   |                             | 11. BIRTHPLACE (State or foreign country)<br>Virginia   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.  |                                |
| 13. FATHER'S NAME<br>John Ruse   |                           |   |                             | 14. MOTHER'S MAIDEN NAME<br>Olivia E. George  |  |   |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br>no  |                           | 16. SOCIAL SECURITY NO.<br>none   |                             | 17. INFORMANT<br>Grafton Cost, Braddock Heights, Md.  |  |   |                                |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral Hemorrhage<br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Advanced Arterio Sclerosis<br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br>4 mo |                           |   |                             |   |  |   |                                |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           |   |                             |   |  |   |                                |
| <b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>  |                           |   |                             |   |  |   |                                |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                           |   |                             |   |  |   |                                |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br>19  |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                             | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |                                |
| 21. I certify that I attended the deceased from July 11, 1961, to July 19, 1961, that I last saw the deceased alive on July 11, 1961, and that death occurred at 6:30 P.M. from the causes and on the date stated above.   |                           |   |                             |   |  |   |                                |
| ACTUAL SIGNATURE<br>J. Elmer Harp M.D.   |                           |   |                             | ADDRESS (Street, city or town, state)<br>Middletown, Md. DATE SIGNED<br>7-20-61   |  |   |                                |
| PHYSICIAN'S NAME (Type)<br>Dr. J. Elmer Harp   |                           |   |                             | Middletown, Md.   |  |   |                                |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>burial  |                           | 22b. DATE THEREOF<br>7/22/1961  |                             | 22c. NAME OF CEMETERY OR CREMATORY<br>St. Mark's Episcopal Cem. Petersburg, Md.   |  | 22d. LOCATION (City, town, or county) (State)   |                                |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Gladhill Company, Middletown, Md.  |                           |   |                             | 24a. REC'D BY REGISTRAR<br>DATE JUL 24 '61  |  | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Howard  |                                |

CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br><i>John Doe</i>                         |  | 2. SEX<br><i>Male</i>  |  |
| 3. AGE<br><i>45</i>  |  | 4. RACE<br><i>White</i>  |  |
| 5. DATE OF BIRTH<br><i>Jan 15, 1925</i>                        |  | 6. PLACE OF BIRTH<br><i>New York City</i>                          |  |
| 7. DATE OF DEATH<br><i>Jan 20, 1970</i>                        |  | 8. PLACE OF DEATH<br><i>Home</i>                                   |  |
| 9. TIME OF DEATH<br><i>10:00 AM</i>                            |  | 10. CAUSE OF DEATH<br><i>Myocardial Infarction</i>                 |  |
| 11. MANNER OF DEATH<br><i>Natural</i>                          |  | 12. SIGNATURE OF PHYSICIAN<br><i>Dr. John Smith</i>                |  |
| 13. SIGNATURE OF REGISTRAR<br><i>John Doe</i>                  |  | 14. SIGNATURE OF WITNESS<br><i>John Doe</i>                        |  |
| 15. SIGNATURE OF DECEASED<br><i>John Doe</i>                   |  | 16. SIGNATURE OF SURVIVOR<br><i>John Doe</i>                       |  |
| 17. SIGNATURE OF NEXT OF KIN<br><i>John Doe</i>                |  | 18. SIGNATURE OF CLERK<br><i>John Doe</i>                          |  |
| 19. SIGNATURE OF CHURCH CLERK<br><i>John Doe</i>               |  | 20. SIGNATURE OF BURIAL CLERK<br><i>John Doe</i>                   |  |
| 21. SIGNATURE OF INTERMENT CLERK<br><i>John Doe</i>            |  | 22. SIGNATURE OF CREMATION CLERK<br><i>John Doe</i>                |  |
| 23. SIGNATURE OF CORONER<br><i>John Doe</i>                    |  | 24. SIGNATURE OF JURY<br><i>John Doe</i>                           |  |
| 25. SIGNATURE OF JUDGE<br><i>John Doe</i>                      |  | 26. SIGNATURE OF DISTRICT ATTORNEY<br><i>John Doe</i>              |  |
| 27. SIGNATURE OF STATE ATTORNEY<br><i>John Doe</i>             |  | 28. SIGNATURE OF ATTORNEY GENERAL<br><i>John Doe</i>               |  |
| 29. SIGNATURE OF SECRETARY OF STATE<br><i>John Doe</i>         |  | 30. SIGNATURE OF COMMISSIONER OF HEALTH<br><i>John Doe</i>         |  |
| 31. SIGNATURE OF DEPUTY COMMISSIONER<br><i>John Doe</i>        |  | 32. SIGNATURE OF ASSISTANT COMMISSIONER<br><i>John Doe</i>         |  |
| 33. SIGNATURE OF CHIEF OF BUREAU<br><i>John Doe</i>            |  | 34. SIGNATURE OF SUPERVISOR<br><i>John Doe</i>                     |  |
| 35. SIGNATURE OF CLERK<br><i>John Doe</i>                      |  | 36. SIGNATURE OF RECEPTIONIST<br><i>John Doe</i>                   |  |
| 37. SIGNATURE OF MAIL ROOM<br><i>John Doe</i>                  |  | 38. SIGNATURE OF TELEPHONE ROOM<br><i>John Doe</i>                 |  |
| 39. SIGNATURE OF RECORDS ROOM<br><i>John Doe</i>               |  | 40. SIGNATURE OF GENERAL INVESTIGATIVE DIVISION<br><i>John Doe</i> |  |
| 41. SIGNATURE OF IDENTIFICATION DIVISION<br><i>John Doe</i>    |  | 42. SIGNATURE OF LABORATORY DIVISION<br><i>John Doe</i>            |  |
| 43. SIGNATURE OF RADIOLOGICAL DIVISION<br><i>John Doe</i>      |  | 44. SIGNATURE OF PATHOLOGICAL DIVISION<br><i>John Doe</i>          |  |
| 45. SIGNATURE OF ANATOMICAL DIVISION<br><i>John Doe</i>        |  | 46. SIGNATURE OF HISTOLOGICAL DIVISION<br><i>John Doe</i>          |  |
| 47. SIGNATURE OF MICROSCOPICAL DIVISION<br><i>John Doe</i>     |  | 48. SIGNATURE OF BACTERIOLOGICAL DIVISION<br><i>John Doe</i>       |  |
| 49. SIGNATURE OF MYCOLOGICAL DIVISION<br><i>John Doe</i>       |  | 50. SIGNATURE OF PARASITOLOGICAL DIVISION<br><i>John Doe</i>       |  |
| 51. SIGNATURE OF ZOOLOGICAL DIVISION<br><i>John Doe</i>        |  | 52. SIGNATURE OF BOTANICAL DIVISION<br><i>John Doe</i>             |  |
| 53. SIGNATURE OF AGRICULTURAL DIVISION<br><i>John Doe</i>      |  | 54. SIGNATURE OF FORESTRY DIVISION<br><i>John Doe</i>              |  |
| 55. SIGNATURE OF FISHERY DIVISION<br><i>John Doe</i>           |  | 56. SIGNATURE OF WILDLIFE DIVISION<br><i>John Doe</i>              |  |
| 57. SIGNATURE OF MARINE DIVISION<br><i>John Doe</i>            |  | 58. SIGNATURE OF COAST AND GEODETIC SURVEY<br><i>John Doe</i>      |  |
| 59. SIGNATURE OF AERONAUTICS DIVISION<br><i>John Doe</i>       |  | 60. SIGNATURE OF SPACE DIVISION<br><i>John Doe</i>                 |  |
| 61. SIGNATURE OF METEOROLOGY DIVISION<br><i>John Doe</i>       |  | 62. SIGNATURE OF CLIMATE DIVISION<br><i>John Doe</i>               |  |
| 63. SIGNATURE OF SOIL CONSERVATION DIVISION<br><i>John Doe</i> |  | 64. SIGNATURE OF WATER RESOURCES DIVISION<br><i>John Doe</i>       |  |
| 65. SIGNATURE OF PUBLIC WORKS DIVISION<br><i>John Doe</i>      |  | 66. SIGNATURE OF HIGHWAYS DIVISION<br><i>John Doe</i>              |  |
| 67. SIGNATURE OF BRIDGES DIVISION<br><i>John Doe</i>           |  | 68. SIGNATURE OF PORTS DIVISION<br><i>John Doe</i>                 |  |
| 69. SIGNATURE OF AIRPORTS DIVISION<br><i>John Doe</i>          |  | 70. SIGNATURE OF NAVIGATION DIVISION<br><i>John Doe</i>            |  |
| 71. SIGNATURE OF MARITIME DIVISION<br><i>John Doe</i>          |  | 72. SIGNATURE OF SHIPPING DIVISION<br><i>John Doe</i>              |  |
| 73. SIGNATURE OF COMMERCE DIVISION<br><i>John Doe</i>          |  | 74. SIGNATURE OF INDUSTRY DIVISION<br><i>John Doe</i>              |  |
| 75. SIGNATURE OF LABOR DIVISION<br><i>John Doe</i>             |  | 76. SIGNATURE OF EMPLOYMENT DIVISION<br><i>John Doe</i>            |  |
| 77. SIGNATURE OF TRAINING DIVISION<br><i>John Doe</i>          |  | 78. SIGNATURE OF RESEARCH DIVISION<br><i>John Doe</i>              |  |
| 79. SIGNATURE OF DEVELOPMENT DIVISION<br><i>John Doe</i>       |  | 80. SIGNATURE OF PLANNING DIVISION<br><i>John Doe</i>              |  |
| 81. SIGNATURE OF POLICY DIVISION<br><i>John Doe</i>            |  | 82. SIGNATURE OF LEGAL DIVISION<br><i>John Doe</i>                 |  |
| 83. SIGNATURE OF FINANCE DIVISION<br><i>John Doe</i>           |  | 84. SIGNATURE OF PERSONNEL DIVISION<br><i>John Doe</i>             |  |
| 85. SIGNATURE OF INFORMATION DIVISION<br><i>John Doe</i>       |  | 86. SIGNATURE OF COMMUNICATIONS DIVISION<br><i>John Doe</i>        |  |
| 87. SIGNATURE OF PUBLIC RELATIONS DIVISION<br><i>John Doe</i>  |  | 88. SIGNATURE OF MEDIA DIVISION<br><i>John Doe</i>                 |  |
| 89. SIGNATURE OF ADVERTISING DIVISION<br><i>John Doe</i>       |  | 90. SIGNATURE OF MARKETING DIVISION<br><i>John Doe</i>             |  |
| 91. SIGNATURE OF SALES DIVISION<br><i>John Doe</i>             |  | 92. SIGNATURE OF DISTRIBUTION DIVISION<br><i>John Doe</i>          |  |
| 93. SIGNATURE OF LOGISTICS DIVISION<br><i>John Doe</i>         |  | 94. SIGNATURE OF SUPPLY DIVISION<br><i>John Doe</i>                |  |
| 95. SIGNATURE OF PROCUREMENT DIVISION<br><i>John Doe</i>       |  | 96. SIGNATURE OF CONTRACTS DIVISION<br><i>John Doe</i>             |  |
| 97. SIGNATURE OF LEGAL COUNSEL DIVISION<br><i>John Doe</i>     |  | 98. SIGNATURE OF INSURANCE DIVISION<br><i>John Doe</i>             |  |
| 99. SIGNATURE OF RISK MANAGEMENT DIVISION<br><i>John Doe</i>   |  | 100. SIGNATURE OF COMPLIANCE DIVISION<br><i>John Doe</i>           |  |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. RACE  
5. DATE OF BIRTH  
6. PLACE OF BIRTH  
7. DATE OF DEATH  
8. PLACE OF DEATH  
9. TIME OF DEATH  
10. CAUSE OF DEATH  
11. MANNER OF DEATH  
12. SIGNATURE OF PHYSICIAN  
13. SIGNATURE OF REGISTRAR  
14. SIGNATURE OF WITNESS  
15. SIGNATURE OF DECEASED  
16. SIGNATURE OF SURVIVOR  
17. SIGNATURE OF NEXT OF KIN  
18. SIGNATURE OF CLERK  
19. SIGNATURE OF CHURCH CLERK  
20. SIGNATURE OF BURIAL CLERK  
21. SIGNATURE OF INTERMENT CLERK  
22. SIGNATURE OF CREMATION CLERK  
23. SIGNATURE OF CORONER  
24. SIGNATURE OF JURY  
25. SIGNATURE OF JUDGE  
26. SIGNATURE OF DISTRICT ATTORNEY  
27. SIGNATURE OF STATE ATTORNEY  
28. SIGNATURE OF ATTORNEY GENERAL  
29. SIGNATURE OF SECRETARY OF STATE  
30. SIGNATURE OF COMMISSIONER OF HEALTH  
31. SIGNATURE OF DEPUTY COMMISSIONER  
32. SIGNATURE OF ASSISTANT COMMISSIONER  
33. SIGNATURE OF CHIEF OF BUREAU  
34. SIGNATURE OF SUPERVISOR  
35. SIGNATURE OF CLERK  
36. SIGNATURE OF RECEPTIONIST  
37. SIGNATURE OF MAIL ROOM  
38. SIGNATURE OF TELEPHONE ROOM  
39. SIGNATURE OF RECORDS ROOM  
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96. SIGNATURE OF CONTRACTS DIVISION  
97. SIGNATURE OF LEGAL COUNSEL DIVISION  
98. SIGNATURE OF INSURANCE DIVISION  
99. SIGNATURE OF RISK MANAGEMENT DIVISION  
100. SIGNATURE OF COMPLIANCE DIVISION

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7949

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07941

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>                |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Adamstown RD I</u>  |  |   |  | c. LENGTH OF STAY IN 1b<br><u>9 months</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |  |   |  | d. STREET ADDRESS<br><u>X Adamstown RD I</u>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Rosa</u> Middle <u>Baker</u> Last <u>Baker</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>8</u> Year <u>1961</u>   |  |   |  |
| 5. SEX<br><u>Female</u>  |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>May 23, 1892</u>                                 |  |
| 9. AGE (In years last birthday)<br><u>69</u> yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House wife</u> |  | 11. BIRTHPLACE (State or foreign country)<br><u>Montgomery Co</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                           |  |
| 13. FATHER'S NAME<br><u>Benjamin F. Roberson</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary F. Purdy</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)   |  | 17. INFORMANT<br><u>William Baker Adamstown Rd I</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. DUE TO (c)  |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                    |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour <u>19</u> a. m. p. m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>       |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                    |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <u>B. O. Thomas</u> M.D.  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| EXAMINER'S NAME (Type) <u>B. O. Thomas, M.D.</u>   |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
|  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>July 8, 1961</u>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>7/11/61</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Monocacy</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Beallsville, Md</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>William C. Hiltz, Barnesville</u>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>JUL 14 '61</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Charles L. Kneass</u>                  |  |

MEDICAL CERTIFICATION

2

10X11.5

Index

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7950  
CERTIFICATE OF DEATH

07942

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Brunswick</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>25</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>512 9th Avenue</b>  |                                  | d. STREET ADDRESS<br><b>512 9th Avenue</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Bertha</b> Middle <b>Aramanta</b> Last <b>Bohrer</b>   |                                  | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>19</b> Year <b>1961</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>6-13-1879</b>                   |
| 9. AGE (In years last birthday)<br><b>82</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>19</b>   | 11. IF UNDER 24 HRS.<br>Hours <b>19</b> Min. <b>19</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Robert Michael HUBERTSON</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Maggie Laign</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>Mr. Hubert Bohrers, Brunswick, Maryland</b>   |  |
| 17. INFORMANT<br><b>Mr. Hubert Bohrers, Brunswick, Maryland</b>  |                                  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Heart Failure</b><br>592X DUE TO (b) <b>Chronic Hypertensive Nephritis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>??</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m. <b>19</b><br>p.m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7/16</b> to <b>7/19</b> , 19 <b>61</b> , that (I) <b>last</b> saw the deceased alive on <b>7/19</b> , 19 <b>61</b> , and that death occurred at <b>7:45</b> from the causes and on the date stated above. |                                  | 22a. SIGNATURE<br><b>W.B. Carpenter</b>   |  |
| 22b. DATE<br><b>7/21/61</b>  |                                  | 22c. PHYSICIAN'S NAME (Type)<br><b>W.B. Carpenter</b>   |  |
| 22d. ADDRESS<br><b>Brunswick, Md</b>   |                                  | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>7-23-1961</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Park Heights</b>  |                                  | 23d. LOCATION (City, town or County) (State)<br><b>Brunswick, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>B. L. Fule Brunswick, Maryland</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>JBL 25 '61</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Korman</b>  |                                  | 25c. DATE<br><b>7/25/61</b>   |  |

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Chronic Hepatic Disease  
11

10/10/01  
10/10/01  
10/10/01

W.D. Carpenter  
10/10/01



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is not taken to the hospital, the death certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7951  
CERTIFICATE OF DEATH

07943

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b><br>c. LENGTH OF STAY IN 1b<br><b>3 mo.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Montevue</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Frederick</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b><br>d. STREET ADDRESS<br><b>Frederick, Maryland.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Anna Elizabeth Britton</b>   |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>30</b> Year <b>19 61</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>Feb. 17, 1890</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Housework</b>  | 9. AGE (In years last birthday)<br><b>71</b> yrs.<br>IF UNDER 1 YEAR<br>Months <b>10</b> Days <b>15</b><br>IF UNDER 24 HRS.<br>Hours <b>2</b> Min. <b>45</b> |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Johnsville, Maryland.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Charles Funk</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Margaret Smith</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  |
| 17. INFORMANT<br><b>J. Edgar Britton, Route #5, Frederick, Maryland.</b>  |                                  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO<br><b>Atherosclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>10 min.</b><br><b>2 YRS.</b> |                                  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Apr 19</b> 19 <b>61</b> to <b>July 27</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>July 27</b> 19 <b>61</b> , and that death occurred at <b>5:20 AM</b> from the causes and on the date stated above.  |                                  |  |  |
| 22a. SIGNATURE<br><b>H.F. Kline</b><br>M.D.   |                                  | 22b. DATE SIGNED<br><b>July 31 1961</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>H.F. Kline, Sr. M.D.</b>   |                                  | 22d. ADDRESS<br><b>7 North Market St. Frederick, Maryland.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>8/1/61</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Frederick Memorial Park</b>  |                                  | 23d. LOCATION (City, town or county) (State)<br><b>Frederick, Maryland.</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>M.R. Etchison &amp; Son, 106 E. Church St. Frederick, Md.</b>  |                                  | 25. RECEIVED BY REGISTRAR<br><b>AUG 2 1961</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |                                  | DATE   |  |

07843

2052

(M)

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Frederick, Maryland

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Frederick, Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7952

## CERTIFICATE OF DEATH

07944

Item 23 Film 0292 7/31/61 iwk

|  |                               |  |                                  |
|--|-------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b><br>c. LENGTH OF STAY IN 1b <b>Lifetime</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>307 College Place</b>   |                               | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Frederick</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b><br>d. STREET ADDRESS <b>307 College Place</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  |
| 3. NAME OF DECEASED (Type or print) <b>Clarence A. Bussard</b>   |                               | 4. DATE OF DEATH <b>July 22, 1961</b>  |                                  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>2-7-1883</b> |
| 9. AGE (In years last birthday) <b>78</b> yrs.   |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farm Implement Dealer</b>   |                               | 11. BIRTHPLACE (County & State, or foreign country) <b>Frederick County, Maryland</b>  |                                  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                               | 13. FATHER'S NAME <b>Joseph Hanson Bussard</b>   |                                  |
| 14. MOTHER'S MAIDEN NAME <b>Susan Catherine Angell</b>   |                               | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes give war or dates of service) <b>No</b>  |                                  |
| 16. SOCIAL SECURITY NO. <b>None</b>  |                               | 17. INFORMANT Address  |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO <b>241X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, }<br>(b) <b>Cardio vascular disease</b><br>(c) <b>Bronchial Asthma</b> |                               | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 1/2 hrs</b><br><b>5 yrs. +</b><br><b>5 yrs. +</b>   |                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               |  |                                  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |                                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1952</b> to <b>July 22, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 20, 1961</b> , and that death occurred at <b>3A</b> M, from the causes and on the date stated above.   |                               |  |                                  |
| 22a. SIGNATURE <b>B. O. Thomas</b> M.D.  |                               | 22b. DATE SIGNED <b>7/22/61</b>  |                                  |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. B. O. Thomas, Sr.</b> M.D.   |                               | 22d. ADDRESS <b>228 North Market Street Frederick, Md.</b>   |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>  |                               | 23b. DATE THEREOF <b>July 25, 1961</b>   |                                  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>  |                               | 23d. LOCATION (City, town or county) (State) <b>Frederick, Md.</b>   |                                  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Dailey &amp; Son</b> ADDRESS <b>Frederick, Maryland</b>  |                               | 25a. REC'D BY REGISTRAR <b>JUL 26 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>  |                                  |

(M)

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Frederick

Frederick

Mission

Frederick

507 College Place

Quincy

507 College Place

Quincy

White

2-7-1987

78

Added from Business Ledger

Joseph Samuel Bernard

Frederick County, Maryland, U.S.A.

Sharon Catherine Apple

no

Howe

C

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1987

1987

Robert A. Bailey & Son, Frederick, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7953

CERTIFICATE OF DEATH

07945

Reg. Dist. No.

|  |                           |  |                                    |  |  |  |                  |
|--|---------------------------|--|------------------------------------|--|--|--|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>FREDERICK</u> MARYLAND   |                           |  |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> |  |  |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>  |                           |  |                                    | c. LENGTH OF STAY IN 1b <u>4 WEEKS</u>   |  |  |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>  |                           |  |                                    | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |                  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>GLADYS IRENE CLABAUGH</u>   |                           |  |                                    | 4. DATE OF DEATH Month Day Year <u>JULY 14 1961</u>  |  |  |                  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>NOV 9-1922</u> | 9. AGE (In years last birthday) <u>38</u> yrs.   | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>  |                                    | 11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |                  |
| 13. FATHER'S NAME <u>JOHN KRAMER</u>   |                           |  |                                    | 14. MOTHER'S MAIDEN NAME <u>CELESTE MANGLE</u>   |  |  |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |                           | 16. SOCIAL SECURITY NO. <u>NO</u>  |                                    | 17. INFORMANT <u>CARROLL CLABAUGH</u>  |  | Address <u>MD UNION BRIDGE</u>   |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Bacterial endocarditis</u><br><u>430.0</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Hemolytic Staph. aureus</u><br>DUE TO<br>(c) _____ |                           |  |                                    |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>  |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                           |  |                                    |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                    |  |  |  |                  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |                  |
| 21. I certify that I attended the deceased from <u>June 16</u> , 19 <u>61</u> , to <u>July 14</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 14</u> , 19 <u>61</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.  |                           |  |                                    |  |  |  |                  |
| ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D.  |                           |  |                                    | ADDRESS (Street, city or town, state) <u>4 E. Church St</u>  |  | DATE SIGNED <u>7/15/61</u>   |                  |
| PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>  |                           |  |                                    | <u>Frederick Maryland</u>  |  |  |                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |                           | 22b. DATE THEREOF <u>7/18/61</u>   |                                    | 22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>CARROLL CO MD</u>                             |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>D. Hartzler &amp; Sons</u>   |                           |  |                                    | ADDRESS <u>Union Bridge Md</u>   |  | 24a. REC'D BY REGISTRAR DATE <u>JUL 19 '61</u>   |                  |
|  |                           |  |                                    | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>   |  |  |                  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7954

07946

|   |   |  |  |
|---|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Frederick Co.</b> MARYLAND   |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mt. Airy</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick Memorial Hospital</b>  |   | d. STREET ADDRESS<br><b>711 N. Main Street</b>   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <b>Charles</b> Middle <b>F.</b> Last <b>Clutter</b>   |   | <b>4. DATE OF DEATH</b><br>Month <b>July</b> Day <b>8</b> Year <b>1961</b>   |  |
| <b>5. SEX</b><br><b>Male</b>  | <b>6. COLOR OR RACE</b><br><b>White</b> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><b>October 15, 1882</b> |
| <b>9. AGE</b> (In years (last birthday) yrs.)<br><b>78</b>  |   | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Minister--Retired</b>                                      |  |
| <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |   | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Pennsylvania</b>  |  |
| <b>13. FATHER'S NAME</b><br><b>Samuel Clutter</b>   |   | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Margaret Vance</b>   |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)  |   | <b>17. INFORMANT</b> Address<br><b>Mr. Charles W. Clutter, Mt. Airy, Md.</b>   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Haemorrhage</b><br><b>331X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b><br>DUE TO (c) |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 days</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis - Cerebral Haemorrhage Oct. 1958</b>  |   |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a. m. p. m. 19  |   | <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>    |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |   | <b>20f. (City or town)</b> (County) (State)  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from July 7, 1961, to July 8, 1961, that (I) (we) last saw the deceased alive on July 8, 1961, and that death occurred at 1 P.M., from the causes and on the date stated above.</b>   |   |  |  |
| <b>22a. SIGNATURE</b><br><b>G. A. Pearre, M.D.</b>  |   | <b>22b. DATE SIGNED</b><br><b>7/8/61</b>   |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><b>A. A. Pearre, M. D.</b>   |   | <b>22d. ADDRESS</b><br><b>Frederick, Md.</b>   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>Burial</b>   |   | <b>23b. DATE THEREOF</b><br><b>7-12, 1961</b>  |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Reformed Church of Mahwah, Bergen Co., N. J.</b>  |   | <b>23d. LOCATION</b> (City, town, or county) (State)   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>C. M. Waltz,</b>  |   | <b>25a. REC'D BY REGISTRAR</b><br><b>JUL 10 1961</b>   |  |
| <b>ADDRESS</b><br><b>Winfield, Maryland</b>   |   | <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Arthur S. Harris</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07947

|  |   |  |  |   |   |
|--|---|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Braddock Heights</b><br>c. LENGTH OF STAY IN 1b <b>MARYLAND</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Vindobona Convalescent &amp; Rest Home</b>   |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Frederick</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Buckeystown</b><br>d. STREET ADDRESS <b>X</b><br>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   |
| 3. NAME OF DECEASED (Type or print) <b>SARAH MAUDE DERR</b>  |   |  | 4. DATE OF DEATH <b>July 3, 1961</b>   |   |   |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>30 Dec 1880</b>  | 9. AGE (In years last birthday) <b>80</b> yrs.                      | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> |   |
| 13. FATHER'S NAME <b>David H. Roelkey</b>  |   |  | 14. MOTHER'S MAIDEN NAME <b>Martha A. Renn</b>   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |   | 16. SOCIAL SECURITY NO. <b>None</b>  |  | 17. INFORMANT <b>Mrs. Dorothy D. Rensburg</b> (Same as item #2)     |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.00</b> <b>arteriosclerotic heart disease and Diabetes Mellitus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO (b) <b>Diabetes Mellitus</b><br>DUE TO (c) <b>Diabetic gangrene leg - 2 mos</b> |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1957</b><br><b>1956 +</b>    |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetic gangrene leg - 2 mos</b>   |   |  |  |   |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town)  | (County)  | (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May 19, 1961</b> to <b>July 3, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 19, 1961</b> , and that death occurred <b>12:50A</b> from the causes and on the date stated above.   |   |  |  |   |   |
| 22a. SIGNATURE <b>Charles H. Conley, Jr.</b>   |   | 22b. DATE SIGNED <b>5 July 1961</b>  |  | 22c. ADDRESS <b>228 N. Market St., Frederick, Maryland</b>          |   |
| 22d. PHYSICIAN'S NAME (Type) <b>Charles H. Conley, Jr.</b>   |   |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 23b. DATE THEREOF <b>7-6-61</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Cemetery</b>  | 23d. LOCATION (City, town or county) <b>Feagaville, Maryland</b> (State)   |   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>  |   | 25a. REC'D BY REGISTRAR <b>JUL 7 '61</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>                   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and in any event, within 72 hours after death, be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07948

7956

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|---|---|--|--|
| 1. PLACE OF DEATH<br>e. COUNTY<br><b>Frederick</b><br>MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Frederick</b>    |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |   | c. LENGTH OF STAY IN 1b<br><b>years</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Wynell Nursing Home</b>  |   | d. STREET ADDRESS<br><b>170 West Patrick Street</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Mamie E. Dill</b>  |   | 4. DATE OF DEATH<br><b>July 26, 1961</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 25, 1877</b>                                   |
| 9. AGE (In years last birthday)<br><b>84</b> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Practical Nurse</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Frederick County, Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Joshua Adam Dill</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>L. Higgins</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  |
| 17. INFORMANT<br><b>Mr. LeRoy Grove</b>   |   | 18. ADDRESS<br><b>1421 South Fairview Avenue Park Ridge, Illinois</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br><b>332X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis</b><br>(a), stating the underlying cause last. DUE TO (c) |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 mo.</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>Hypertension - Cardio-Vascular Disease</b>  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OF CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Hour e.m. p.m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 15, 1961</b> to <b>July 26, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 19, 1961</b> , and that death occurred at <b>5A</b> M, from the causes and on the date stated above.  |   |  |  |
| 22a. SIGNATURE<br><b>A. P. Pearre</b><br>M.D.   |   | 22b. DATE SIGNED<br><b>7-26-1961</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. A. Austin Pearre</b>   |   | 22d. ADDRESS<br><b>4 East Church Street Frederick, Maryland</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>7-28-1961</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>   | 23d. LOCATION (City, town or county) (State)<br><b>Frederick, Maryland</b> |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert E. Dailey &amp; Son</b>   |   | 25a. REC'D BY REGISTRAR<br><b>JUL 27 '61</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>C. E. S. Lewis</b>   |   |  |  |

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CERTIFICATE OF DEATH

Reg. Dist. No. 07949

|   |                           |  |  |  |  |  |                                      |
|---|---------------------------|--|--|--|--|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick</u> MARYLAND  |                           |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> |  |  |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>   |                           |  |  | c. LENGTH OF STAY IN 1b <u>24 hrs.</u> X <u>Woodsboro</u>  |  |  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>   |                           |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |                                      |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY CHARLES DORCUS</u>   |                           |  |  | 4. DATE OF DEATH Month Day Year <u>July 11 1961</u>  |  |  |                                      |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 7, 1890</u>   | 9. AGE (In years last birthday) <u>70</u> yrs.   | IF UNDER 1 YEAR Months Days Hours                                      |  | IF UNDER 24 HRS. Min.                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store keeper - own business - General Merchant</u>   |                           |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                      |
| 13. FATHER'S NAME <u>Charles W. Dorcus</u>  |                           |  |  | 14. MOTHER'S MAIDEN NAME <u>Emma Feiser</u>  |  |  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                           | 16. SOCIAL SECURITY NO. <u>-</u>   |  | 17. INFORMANT <u>Mrs. Harry C. Dorcus, Woodsboro, Md</u>   |  | Address  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hemorrhage &amp; shock</u><br>581.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Ruptured &amp; bleeding esophageal varices</u><br>DUE TO<br>(c) <u>Portal cirrhosis, liver</u> |                           |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u><br><u>2 days</u><br><u>2 1/2 years</u> |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic cardiovascular disease 15 years</u>   |                           |  |  |  |  |  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |                           |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>May 19, 55</u> to <u>11 July 1961</u> , that I last saw the deceased alive on <u>11 July 1961</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.  |                           |  |  |  |  |  |                                      |
| ACTUAL SIGNATURE <u>James S. Stoner, Jr.</u> M.D.   |                           |  |  | ADDRESS (Street, city or town, state) <u>Walkersville, Md</u> DATE SIGNED <u>7/12/61</u>   |  |  |                                      |
| PHYSICIAN'S NAME (Type) <u>JAMES E. STONER, JR.</u>   |                           |  |  |  |  |  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                           | 22b. DATE THEREOF <u>7/14/61</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Woodsboro Md.</u>                       |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton, Walkersville, Md.</u> ADDRESS   |                           |  |  | 24a. REC'D BY REGISTRAR DATE <u>JUL 17 '61</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>                                       |                                      |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

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# CERTIFICATE OF DEATH

Reg. Dist. No. 07950

|   |                                  |   |                                     |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                   |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>1 Day</b>   |                                     |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |                                  | d. STREET ADDRESS<br><b>38 Lincoln Apt</b>  |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick Memorial</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>Henry</b> Last <b>Dorsey</b>   |                                  | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>16</b> Year <b>1961</b>   |                                     |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3-5-1885</b> |
| 9. AGE (In years less birthday) yrs.<br><b>76</b>   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>*****</b>   |                                     |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |                                     |
| 13. FATHER'S NAME<br><b>Joseph Dorsey</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Putman</b>   |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>219-20-4067</b>   |                                     |
| INFORMANT<br><b>Dora Dorsey Moore</b>   |                                  | Address<br><b>38 Lincoln Apt</b>  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary Heart Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Dis.</b> DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b><br><b>1 year</b>  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work  |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that I attended the deceased from <b>Apr</b> 1961, to <b>July 16</b> 1961, that I last saw the deceased alive on <b>July 16</b> 1961, and that death occurred at <b>11:45</b> P. M. from the causes and on the date stated above.   |                                  |   |                                     |
| ACTUAL SIGNATURE <b>J. Hicks</b> M.D.   |                                  | ADDRESS (Street, city or town, state) <b>Frederick, Md</b> DATE SIGNED  |                                     |
| PHYSICIAN'S NAME (Type)   |                                  |   |                                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>7-19-61</b>   |                                     |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Dorsey Chapel</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick Co. Maryland</b>  |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>C.E. Hicks, III</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>JUL 21 1961</b>   |                                     |
| ADDRESS<br><b>Frederick Maryland</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b>   |                                     |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7959

CERTIFICATE OF DEATH

Reg. Dist. No. 07951

|   |                                 |  |   |
|---|---------------------------------|--|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Frederick</u> MARYLAND   |                                 | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mt Airy</u>   |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Airy - Rural</u>  |   |
| c. LENGTH OF STAY IN 1b <u>50 years</u>   |                                 | d. STREET ADDRESS <u>1 Route 1 - (sidney)</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home - Route 1</u>  |                                 | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| <b>3. NAME OF DECEASED</b> (Type or print) First <u>Isaac</u> Middle <u>Zachariah</u> Last <u>Dotson</u>  |                                 | <b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>14</u> Year <u>1961</u>   |   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 19, 1870</u>                     |
| 9. AGE (In years last birthday) <u>90</u> yrs.  |                                 | IF UNDER 1 YEAR Months Days Hours Min.   | IF UNDER 24 HRS. Months Days Hours Min.                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Leborer</u>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>  | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |                                 | 13. FATHER'S NAME <u>John Wesley Dotson</u>  |   |
| 14. MOTHER'S MAIDEN NAME <u>Elizabeth Thomas</u>  |                                 | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)                                      |   |
| 16. SOCIAL SECURITY NO. <u>-NO-</u>   |                                 | INFORMANT <u>Margaret Johnson, Mt. Airy, Md</u> Address  |   |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u><br><u>491X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ |                                 | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |                                 |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                 |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____  |                                 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>                          |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                 | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>March</u> , 19 <u>55</u> , to <u>July</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 12</u> , 19 <u>61</u> , and that death occurred at <u>5:30</u> A.M., from the causes and on the date stated above.  |                                 |  |   |
| ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D.   |                                 | ADDRESS (Street, city or town, state) <u>Mt. Airy, Md</u> DATE SIGNED <u>July 14, 1961</u>   |   |
| PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u> M.D.  |                                 |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                                 | 22b. DATE THEREOF <u>July 16, 1961</u>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>   |                                 | 22d. LOCATION (City, town, or county) (State) <u>Frederick Co. Maryland</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. WALTZ</u> ADDRESS <u>Winfield, Md.</u>  |                                 | 24. REC'D BY REGISTRAR DATE <u>JUL 17 '61</u>  |   |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>  |                                 |  |   |

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*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7960

## CERTIFICATE OF DEATH

07952

|   |  |  |   |
|---|--|--|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Frederick</b> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b><br>c. LENGTH OF STAY IN 1b <b>Years</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick County Chronic Hospital</b>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b><br>d. STREET ADDRESS <b>18 Taney Apartments</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <b>MYRTLE</b> Middle <b>MAMIE</b> Last <b>ESTERLY</b>   |  | <b>4. DATE OF DEATH</b> <b>July 6 1961</b>   |   |
| <b>5. SEX</b><br><b>Female</b>  | <b>6. COLOR OR RACE</b><br><b>White</b>          | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | <b>8. DATE OF BIRTH</b> <b>December 14, 1887</b>  |
| <b>9a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>House-work</b>  | <b>9. AGE</b> (In years last birthday) <b>73</b> yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>Walkersville, Maryland</b>   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>USA</b>  |   |
| <b>13. FATHER'S NAME</b><br><b>Isaac Steel</b>  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Unknown</b>  |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war and dates of service)<br><b>No</b>  |  | <b>16. SOCIAL SECURITY NO.</b>   |   |
| <b>17. INFORMANT</b><br><b>Mr. LeRoy E. Hood</b>  |  | <b>720 Charing Cross Roads</b><br><b>Baltimore 29, Maryland</b>  |   |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma Uterus</b><br>174X DUE TO (b) <b>Chronic coded vascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying causa last. } DUE TO (c) <b>Bronchial Asthma</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b><br><b>3 yrs.</b><br><b>3 yrs.</b> |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   |
| <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  | <b>20f. (City or town) (County) (State)</b>  |   |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>July 5, 1961</b> <b>to July 5, 1961</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>July 5, 1961</b> , and that death occurred at <b>1:30 AM</b> from the causes and on the date stated above.   |  |  |   |
| <b>22a. SIGNATURE</b><br><b>Horace D. Kline</b> M.D.  |  | <b>22b. DATE SIGNED</b><br><b>July 7, 1961</b>   |   |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><b>H. F. Kline M.D.</b>  |  | <b>22d. ADDRESS</b><br><b>7 North Market St. Frederick, Maryland</b>   |   |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>   | <b>23b. DATE THEREOF</b><br><b>July 10, 1961</b> | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Mount Olivet Cemetery</b>  | <b>23d. LOCATION (City, town or county) (State)</b><br><b>Frederick Maryland</b>  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>M. R. Etchison and Son, Frederick, Maryland</b>   |  | <b>25a. REC'D BY REGISTRAR</b> <b>JUL 10 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Arthur S. Kline</b>   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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7951  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
07953

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#4</b><br>c. LENGTH OF STAY IN 1b <b>Life</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Feagaville</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Frederick</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#4</b><br>d. STREET ADDRESS <b>Feagaville</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br><b>HARRY MILTON FEAGA</b>  |                                  | 4. DATE OF DEATH<br><b>July 19, 1961</b>   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>13 March 1886</b> |
| 9. AGE (In years last birthday)<br><b>75 yrs.</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired-Owner</b>  |                                  | 12. BIRTHPLACE (County & State, or foreign country)<br><b>Feagaville, Md.</b>  |  |
| 13. FATHER'S NAME<br><b>Charles E. Feaga</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Unglebower</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>218-30-9776</b>  |  |
| 17. INFORMANT<br><b>Mrs. Maude R. Feaga (Same as item #1)</b>   |                                  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerosis</b><br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>5 min</b><br><b>240.</b> |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 17, 1961</b> to <b>July 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 17, 1961</b> , and that death occurred at <b>9:45A.</b> from the causes and on the date stated above.   |                                  |  |  |
| 22a. SIGNATURE<br><b>H. F. Kline</b><br>M.D.  |                                  | 22b. DATE<br><b>20 July 1961</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>H. F. Kline, M. D.</b>   |                                  | 22d. ADDRESS<br><b>7 N. Market St., Frederick, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>7-21-61</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lutheran Cemetery</b>  |                                  | 23d. LOCATION (City, town or county) (State)<br><b>Feagaville, Md.</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Md.</b>   |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 21 '61</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kline</b>  |                                  |  |  |



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7962  
CERTIFICATE OF DEATH

07954

|   |                               |  |                                      |  |  |  |  |
|---|-------------------------------|--|--------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |                               |  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Braddock Heights</b>  |                               |  |                                      | c. LENGTH OF STAY IN 1b <b>Years</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Schley Inn Braddock Heights</b>   |                               |  |                                      | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>Fischer</b> Last <b>Fischer</b>  |                               |  |                                      | 4. DATE OF DEATH Month <b>July</b> Day <b>8</b> Year <b>19 61</b>  |  |  |  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>June 6, 1894</b> |  | 9. AGE (In years lost birthday) <b>67</b> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.                      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inn Keeper</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |                                      | 11. BIRTHPLACE (State or foreign country) <b>Hungary</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                   |  |
| 13. FATHER'S NAME <b>Joseph Patak (Hungary)</b>   |                               |  |                                      | 14. MOTHER'S MAIDEN NAME <b>Elizabeth Bedner</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                               | 16. SOCIAL SECURITY NO. <b>091-09-9145</b>   |                                      | 17. INFORMANT Address <b>Mr. Hermann Fischer Braddock Hgts. Maryland</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b><br>DUE TO (b) <b>420</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>5 minutes</b> |                               |  |                                      |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>                            |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)   |                               |  |                                      |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                               | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May 18, 1961</b> to <b>July 8, 1961</b> , that (I) (we) lost the deceased alive on <b>July 8, 1961</b> , and that death occurred at <b>9:30</b> M, from the causes and on the date stated above.   |                               |  |                                      |  |  |  |  |
| 22a. SIGNATURE <b>[Signature]</b>   |                               |  |                                      | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                    |  | 22b. DATE SIGNED <b>7/10/61</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. L. R. Schoolman</b>   |                               |  |                                      | 22d. ADDRESS <b>M.D. 810 Tollhouse Avenue Frederick, Maryland</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 23b. DATE THEREOF <b>July 12-1961</b>  |                                      | 23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>   |  | 23d. LOCATION (City, town, or county) (State) <b>Burkittsville- Maryland</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Dailey &amp; Son</b>  |                               |  |                                      | ADDRESS <b>Frederick, Maryland</b>   |  | 25a. REC'D BY REGISTRAR DATE <b>JUL 13 '61</b>                               |  |
|   |                               |  |                                      | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>   |  |  |  |

5225

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7963

## CERTIFICATE OF DEATH

07955

|  |  |   |  |
|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Frederick</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b><br>c. LENGTH OF STAY IN 1b <b>32 yrs.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Own Home</b>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Frederick</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b><br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <b>Wilbur</b> Middle <b>Ross</b> Last <b>Freeze</b>  |  | <b>4. DATE OF DEATH</b><br>Month <b>July</b> Day <b>13</b> Year <b>19 61</b>  |  |
| <b>5. SEX</b><br><b>male</b>   | <b>6. COLOR OR RACE</b><br><b>white</b>  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | <b>8. DATE OF BIRTH</b><br><b>July 17, 1897</b>                                  |
| <b>9. AGE</b> (In years last birthday) <b>63 yrs.</b>  |  | <b>IF UNDER 1 YEAR</b><br>Months <b>63</b> Days <b>0</b>  | <b>IF UNDER 24 HRS.</b><br>Hours <b>0</b> Min. <b>0</b>                          |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Restaurant</b>   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Business</b>  | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>       |
| <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>  |  |   |  |
| <b>13. FATHER'S NAME</b><br><b>Harry Freeze</b>  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Clara Parrish</b>   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)  |  | <b>16. SOCIAL SECURITY NO.</b> <b>218-30-9901</b>   |  |
| <b>17. INFORMANT</b><br><b>Mrs. Mary L. Freeze</b>   |  | <b>Address</b><br><b>Thurmont, Md.</b>  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b><br><b>332X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerosis</b><br>(c) <b>Coronary disease</b> |  |   | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>12 hr.</b><br><b>10 yrs.</b>       |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |
| <b>20c. TIME OF INJURY</b><br>Hour a.m. <b>19</b> p.m. <b>19</b>   | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   | <b>20f. (City or town)</b> (County) (State)                                      |
| <b>21. I certify that (I) (this hospital) attended the deceased from Nov. 15, 1958, to July 13, 1961, that (I) (we) last saw the deceased alive on July 13, 1961, and that death occurred at 3:10 P.M. from the causes and on the date stated above.</b>   |  |   |  |
| <b>22a. SIGNATURE</b><br><b>M. Franklin Birely</b><br>M.D.   |  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>  | <b>22b. DATE SIGNED</b>  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><b>M. Franklin Birely</b>   |  | <b>22d. ADDRESS</b><br><b>Thurmont, Maryland</b>  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>Burial</b>  | <b>23b. DATE THEREOF</b><br><b>7-17-61</b>   | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Blue Ridge Cemetery</b>   | <b>23d. LOCATION</b> (City, town or county) (State)<br><b>Thurmont, Maryland</b> |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>Raymond E. Craven</b>  |  | <b>25a. REC'D BY REGISTRAR</b><br><b>JUL 18 '61</b>   | <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Arthur S. Thomas</b>                     |

(M)

(1)

Thurmont  
Own Home

male white

Restaurant

Harry Treese

No

32 yrs.

Wilbur Ross Treese

x

July 17, 1897

63

On Business

Maryland

Clara Treese

218-30-9901 Mrs. Mary A. Treese

Thurmont, Md.

County House

Thurmont, Maryland

M. Franklin Blevins

Burial

7-17-91

Blue Ridge Cemetery

Thurmont, Maryland

Thurmont, Md.

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July 12

U.S.A.

Thurmont, Md.

12 km.

10 km.

July 13, 1901

July 13, 1901



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7964

Item 9 File G292 8/7/61 iwk

CERTIFICATE OF DEATH

07956

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|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b><br>c. LENGTH OF STAY in 1b <b>14 years</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1205 Oakwood Drive</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b><br>d. STREET ADDRESS <b>1205 Oakwood Drive</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Thomas</b> Middle <b>Austin</b> Last <b>Garner</b>   |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>30</b> Year <b>1961</b>   |  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>Aug. 2, 1897</b>                                 |
| 9. AGE (In years last birthday) <b>63 64/ yrs.</b>   |   | IF UNDER 1 YEAR<br>Months <b>64</b> Days <b>1</b> Hours <b>12</b> Min. <b>00</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Mng. Plumbing &amp; Heating Co.</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Lodge, Virginia</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>  |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>Robert William Garner</b>   |   | 14. MOTHER'S MAIDEN NAME <b>Minnie Neale</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>   |   | 16. SOCIAL SECURITY NO. <b>212-10-2370</b>   |  |
| 17. INFORMANT <b>Mrs. Thomas A. Garner</b>   |   | Address <b>1205 Oakwood Dr. Fred. Md.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arterio sclerosis coronary arteries</b><br>DUE TO (b) <b>1 hour</b><br>DUE TO (c) <b>12 years</b> |   | INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Hour <b>a.m.</b> Month, Day, Year <b>19</b><br>p.m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                 |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan! 1948</b> to <b>July 30, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 25, 1961</b> , and that death occurred <b>3:30 P.M.</b> from the causes and on the date stated above.  |   |  |  |
| 22a. SIGNATURE <b>Bernard C. Thomas, Jr.</b> M.D.  |   | 22b. DATE SIGNED <b>7-31-1961</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. B. O. Thomas, Jr.</b> M.D.   |   | 22d. ADDRESS <b>228 North Market Street Frederick, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 23b. DATE THEREOF <b>8-2-1961</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Hendersons Church Cemetery</b>   | 23d. LOCATION (City, town or county) (State) <b>Callao, Virginia</b> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Dailey &amp; Son</b>   |   | 25a. REC'D BY REGISTRAR <b>AUG 2 '61</b>   |  |
| 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>   |   | 25c. ADDRESS <b>Frederick, Maryland</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

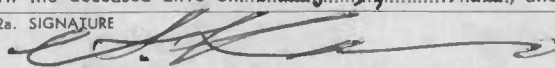
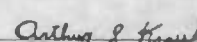
VR A15 (4)  
15M 9/60

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7965

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07957

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Brunswick</b>   |  | c. LENGTH OF STAY IN 1b<br><b>Years</b>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Brunswick</b> <b>35</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>504 Brunswick Street</b>  |  |   |  | d. STREET ADDRESS<br><b>504 Brunswick Street</b>  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>CARROLL GEORGE GRAMS</b>   |  |   |  | 4. DATE OF DEATH<br><b>July 5 1961</b>  |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>November 17, 1913</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Trainman</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>B &amp; O Railroad</b>  |  | 9. AGE (In years last birthday)<br><b>47</b> yrs.   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Frederick County, Maryland</b>                            |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 13. FATHER'S NAME<br><b>Roy E. Grams</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Carrie Hutts</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WW II</b>  |  | 16. SOCIAL SECURITY NO.<br><b>710-09-7223</b>   |  | 17. INFORMANT<br><b>Mrs. Iona M. Grams (Same as Item #2)</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>Congestive Heart Failure</b><br>DUE TO<br>(c) <b>Coronary Insufficiency</b> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hrs.</b><br><b>3 mon.</b><br><b>8 mon.</b>   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 11, 1958</b> to <b>July 5, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 5, 1961</b> , and that death occurred at <b>9:15 PM</b> from the causes and on the date stated above.   |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br>  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22b. DATE SIGNED<br><b>July 7, 1961</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>C. T. Byron Kao M.D.</b>  |  |   |  | 22d. ADDRESS<br><b>Brunswick, Maryland</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>7-8-1961</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Park Heights Cemetery</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>Brunswick Maryland</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison and Son, Frederick, Maryland</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>JUL 10 '61</b>  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |

(M)

(I)

Yes

Nov. 1, 1953

110-22-723 Mrs. John H. Davis (born as John H.)

Charles Davis

U. S. C. Harrison

Frederick County, Maryland

Main White

November 17, 1953

Onward

London

BRMB

July

100 Maryland Street

101 Maryland Street

Frederick

Frederick

Frederick

Frederick

Frederick

M. R. Harrison and Son, Frederick, Maryland

Serial 7-2-1951

Frederick

C. T. Brown and M. R.

Frederick, Maryland

July 7, 1951

July 7, 1951

2:15 PM

Dec. 11, 1951

July 7, 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |  |  |  |   |  |
|--|--|--|---|--|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND   |  |  |   |  |  |  |  |   |  |
| 7966   |  |  |   |  | 07958  |  |  |   |  |
| CERTIFICATE OF DEATH   |  |  |   |  |  |  |  |   |  |
| Information from birth cert.   |  |  |   |  |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>FREDERICK</b>  |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mt. Airy -- Rural</b> |   | c. LENGTH OF STAY IN 1b<br><b>X</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> |  | b. COUNTY <b>Frederick</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Penn Shop Road</b>  |  |  |   |  | e. STREET ADDRESS<br><b>1 Penn Shop Rd.</b>                              |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>BABY</b> Middle <b>BOY</b> Last <b>GRAY</b>   |  |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>14</b> Year <b>1961</b>                                      |  |  |  |  |   |  |
| 5. SEX<br><b>m</b>   |  | 6. COLOR OR RACE<br><b>C</b>   |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>14 July 1961</b>  |  | 9. AGE (In years last birthday) yrs. <b>8</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>DONALD GRAY</b>  |  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>ANN MYERS</b>                             |  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>HOSPITAL RECORDS</b>                                 |  |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br><b>774X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PREMATURITY</b><br>DUE TO (c) |  |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                   |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>14 July 1961</b> to <b>14 July 1961</b> , that (I) (we) last saw the deceased alive on <b>14 July 1961</b> , and that death occurred at <b>7:30</b> P. M. from the causes and on the date stated above.   |  |  |   |  |  |  |  |   |  |
| 22a. SIGNATURE<br><b>F. J. HELDRICH MD</b>   |  |  |   |  | 22b. DATE SIGNED<br><b>14 July 61</b>                                    |  | 22c. PHYSICIAN'S NAME (Type)<br><b>F. J. HELDRICH MD</b>               |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>  |  |  | 23b. DATE THEREOF<br><b>7/25/61</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Frederick Memorial Hospital</b> |  | 23d. LOCATION (City, town, or county) (State)<br><b>Frederick, Md.</b> |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>P. David Youngdale</b>  |  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>Aug 9 '61</b>                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>Chas. E. Kenna</b>                    |   |  |

-1000182 XVI

82073

STATE OF NEW YORK

1905

(M)

(1)

Transmitted to the State of New York



7967

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07959

|  |                                  |  |                                       |
|--|----------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>             |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Brunswick</b> 35  |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Memorial Hospital</b>   |                                  | d. STREET ADDRESS<br><b>4th Avenue Extended</b> 1  |                                       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Nancy</b> Middle <b>Eugenia</b> Last <b>Greaver</b>  |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>5</b> Year <b>1961</b>  |                                       |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-26-1879</b> |
| 9. AGE (In years last birthday)<br><b>81</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                       |
| 13. FATHER'S NAME<br><b>George Ware</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Anderson</b>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.  |                                       |
| 17. INFORMANT<br><b>Mrs. Dorothy Ayers, Brunswick, Maryland</b>  |                                  | Address  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute congestive heart failure</b><br>500X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>acute bronchitis</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>chronic arterio-sclerosis</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>1 week</b> |                                  |  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 5</b> 1961, to <b>July 5</b> 1961, that (I) (we) last saw the deceased alive on <b>July 5</b> 1961, and that death occurred at <b>10:25</b> M, from the causes and on the date stated above.   |                                  |  |                                       |
| 22a. SIGNATURE<br><b>Henry V. Chase</b>  |                                  | 22b. DATE SIGNED<br><b>July 5, 1961</b>  |                                       |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Henry V. Chase</b>  |                                  | 22d. ADDRESS<br><b>4 E. Church St Frederick Md</b>   |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>7-8-1961</b>   |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Edge Hill</b>   |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Charlestown, West Virginia</b>   |                                       |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>B. H. Telle</b>   |                                  | ADDRESS<br><b>Brunswick, Maryland</b>  |                                       |
| 25a. REC'D BY REGISTRAR<br><b>JUL 10 '61</b>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hume</b>  |                                       |

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07960

Reg. Dist. No.

7968

FOR STATE  
HEALTH DEPT.

(M)

|  |                                  |  |  |   |   |
|--|----------------------------------|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>West Virginia</b> COUNTY <b>Jefferson</b> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Brunswick</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>1 day</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Harpers Ferry</b>              |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>B. &amp; O. Railroad Yards</b>  |                                  |  | d. STREET ADDRESS<br><b>High Street</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <b>Charles Augustus</b> First Middle Last  |                                  |  | 4. DATE OF DEATH <b>July 6, 1961</b> Month Day Year  |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                | B. DATE OF BIRTH<br><b>Dec. 15, 1900</b>   |   | 9. AGE (In years last birthday)<br><b>60</b> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Car Repairman</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Loudoun County, Va.</b>   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |
| 13. FATHER'S NAME<br><b>Charles A. Hackley</b>   |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Ella Mae Stoutsenberger</b>   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>225-10-3088</b>  |  | 17. INFORMANT <b>Mrs. Alice Hackley</b><br><b>Harpers Ferry, West Va.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br>(c)   |                                  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town) (County) (State)</b> |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |  |  |   |   |
| ACTUAL SIGNATURE<br><b>James B. Thomas</b>   |                                  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | DATE SIGNED<br><b>7/6/61</b>  |   |
| EXAMINER'S NAME (Type)<br><b>James B. Thomas</b>   |                                  |  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>7/8/61</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fairview Cemetery</b>  |   |
| 22d. LOCATION (City, town, or county)<br><b>Bolivar, West Va.</b>  |                                  | (State)  |  |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Donald Caskle</b>   |                                  | ADDRESS<br><b>Harpers Ferry, W. Va.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>JUL 27 '61</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kenna</b>   |                                  |  |  |   |   |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1962

FOR STATE  
HEALTH DEPT

NAME OF DECEASED: James H. Thomas  
RESIDENCE: 1101 N. E. Street  
CITY: Baltimore

DATE OF DEATH: July 1, 1962  
TIME OF DEATH: 10:00 AM

PLACE OF DEATH: Home  
AGE: 68 YEARS

SEX: Male  
RACE: White

EDUCATION: High School Graduate  
OCCUPATION: Retired

CAUSE OF DEATH: Myocardial Infarction  
MANNER OF DEATH: Natural

DATE OF EXAMINATION: July 1, 1962  
TIME OF EXAMINATION: 11:00 AM

PLACE OF EXAMINATION: Home  
NAME OF EXAMINER: Dr. J. H. Smith

SIGNATURE OF EXAMINER: [Signature]  
DATE: July 1, 1962

NAME OF DECEASED: James H. Thomas  
RESIDENCE: 1101 N. E. Street  
CITY: Baltimore

DATE OF DEATH: July 1, 1962  
TIME OF DEATH: 10:00 AM

PLACE OF DEATH: Home  
AGE: 68 YEARS

SEX: Male  
RACE: White

EDUCATION: High School Graduate  
OCCUPATION: Retired

CAUSE OF DEATH: Myocardial Infarction  
MANNER OF DEATH: Natural

DATE OF EXAMINATION: July 1, 1962  
TIME OF EXAMINATION: 11:00 AM

PLACE OF EXAMINATION: Home  
NAME OF EXAMINER: Dr. J. H. Smith

SIGNATURE OF EXAMINER: [Signature]  
DATE: July 1, 1962

7969

CERTIFICATE OF DEATH

Reg. Dist. No.

07961

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>  |  |   |  |
| c. LENGTH OF STAY IN 1b <b>Hrs.</b>   |  |  |  | d. STREET ADDRESS <b>512 Middle Street</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <b>Margaret Mary Hayes or Mary Margaret</b>   |  |  |  | 4. DATE OF DEATH <b>July 23 19 61</b>  |  |   |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>C</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>May 18-1895</b>                                       |  |
| 9. AGE (In years last birthday) <b>66</b> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min.   |  | IF UNDER 24 HRS. Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House keeper</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Montgomery Co. Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                |  |
| 13. FATHER'S NAME <b>Wilson Owens</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Ella Wallace</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  | 16. SOCIAL SECURITY NO. <b>Unknown</b>   |  | INFORMANT <b>Harry W. Davis-512 Middle St. Fred. Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident - Rt hemiparesis</b><br><b>443X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE ARTERIOSCLEROTIC</b><br>DUE TO (c) <b>CARDIOVASCULAR DISEASE</b> |  |  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hours</b><br><b>&gt; 4 years</b>                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19 p. m.   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                      |  |
| 21. I certify that I attended the deceased from <b>3/7</b> 19 <b>60</b> to <b>7/23</b> 19 <b>61</b> , that I last saw the deceased alive on <b>7/23</b> 19 <b>61</b> , and that death occurred at <b>8:30 P</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>9 E. Church St. Frederick, Md.</b> DATE SIGNED                                     |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Richard C. Reynolds</b> M.D.  |  |  |  |  |  |   |  |
| PHYSICIAN'S NAME (Type) <b>R.C. Reynolds</b>  |  |  |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>7-26-61</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>John Wesley</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Clarksburg, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Hicks 111</b> ADDRESS <b>Frederick, Maryland</b>   |  |  |  | 24a. REC'D BY REGISTRAR DATE <b>JUL 26 '61</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>                         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

51002

7362

CERTIFICATE OF DEATH

State of Maryland  
County of Prince George's  
I, the undersigned, a duly qualified and licensed physician, do hereby certify that  
the within and foregoing is a true and correct copy of the original certificate of death  
of the person named therein, as the same appears from the records of the  
Department of Health, State of Maryland, for the year 1960.  
Witness my hand and the seal of the Department of Health, State of Maryland,  
this 19th day of July, 1960.  
J. Edgar Hoover, Director  
Department of Health, State of Maryland  
1960



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7976

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07962

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>e. COUNTY <b>Frederick</b><br>MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>e. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |  | c. LENGTH OF STAY IN 1b<br><b>44 Yrs</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |  | d. STREET ADDRESS<br><b>32 East Fourth Street</b>                            |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>32 East Fourth Street</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>VERA</b> Middle <b>AMANDA</b> Last <b>HEFFNER</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>5</b> Year <b>1961</b>   |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>11 Sept 1915</b>                                      |  |
| 9. AGE (In years last birthday)<br><b>45</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b></b> Days <b></b>  |  | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Beauty Operator</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Beauty Salon</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>New Midway, Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |  |
| 13. FATHER'S NAME<br><b>Benjamin B. Biehl</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Macy E. Eyler</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>214-10-3861</b>   |  | 17. INFORMANT<br><b>Mrs. Macy E. Biehl</b> <b>327 1/2 Third St.,</b><br><b>Frederick, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Barbituric Acid Poisoning</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>9770.2</b> |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 hours</b>                           |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m. <b></b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>        |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Bernard O. Thomas, Jr.</b><br>EXAMINER'S NAME (Type) <b>Bernard O. Thomas, Jr.</b>  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) <b>Frederick, Maryland</b> |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>7-8-61</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>  |  | 22d. LOCATION (City, town, or country) (State)<br><b>Frederick, Maryland</b> |  |
| 23. FUNERAL DIRECTOR<br>ADDRESS<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br><b>JUL 7 '61</b><br>DATE   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Curtis S. Allen</b>                         |  |

MEDICAL CERTIFICATION

DATE SIGNED

5 July 1961

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HEAT UNIT

Washington

From: Rick

32 East Fourth Street

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Female White

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11 Sept 1915

any person

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Barry, Helen

Barry, Helen

Barry, Helen

no

no-10-1001

Barry, Helen

Barry, Helen

Barry, Helen

Barry, Helen

Barry, Helen

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 7971 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07963

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1, 2, and 3 to the funeral director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>             |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>   |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>  |  |  |  |
| c. LENGTH OF STAY IN life <b>Life</b>   |  |  |  | d. STREET ADDRESS <b>356 Madison Street</b>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>DOA Frederick Memorial Hospital</b>   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANKLIN THOMAS HILDERBRAND, JR.</b>   |  |  |  | 4. DATE OF DEATH Month Day Year <b>July 19, 1961</b>   |  |  |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>1 Feb 1917</b>                                   |  |
| 9. AGE (In years last birthday) <b>44</b> yrs.  |  | IF UNDER 1 YEAR Months Days  |  | IF UNDER 24 HRS. Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Packager</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Everedy Company</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Frederick, Md.</b>      |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  |  | 13. FATHER'S NAME <b>Franklin T. Hilderbrand</b>   |  |  |  |
| 14. MOTHER'S MAIDEN NAME <b>Delpha Fogle</b>  |  |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)  |  |  |  |
| 16. SOCIAL SECURITY NO. <b>220-10-5192</b>  |  |  |  | 17. INFORMANT Address <b>Mrs. Blanche L. Hilderbrand (Same as item #2)</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>                       |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                 |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>B O Thomas</b>  |  |  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
| EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>   |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  |
| Address (Street, city, town, or county)   |  |  |  | DATE SIGNED <b>20 July 1961</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>7-22-61</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>  |  | 22d. LOCATION (City, town, or country) (State) <b>Frederick, Md.</b> |  |
| 23. FUNERAL DIRECTOR ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Md.</b>  |  |  |  | 24a. REC'D BY REGISTRAR <b>JUL 21 '61</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>                   |  |

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7972

CERTIFICATE OF DEATH

07964

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Frederick</b> MARYLAND   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>     |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cullen</b>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>   |  |   |  |
| c. LENGTH OF STAY IN 1b <b>1217 days</b>  |  |  |  | d. STREET ADDRESS <b>229 W. Franklin St.</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Victor Cullen State Hospital</b>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) First <b>William</b> Middle <b>-</b> Last <b>Hooper</b>   |  |  |  | <b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>16</b> Year <b>1961</b>   |  |   |  |
| 5. SEX <b>M.</b>  |  | 6. COLOR OR RACE <b>Wh.</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>10-15-04</b>  |  |
| 9. AGE (In years lost birthday) <b>56</b> yrs.  |  | IF UNDER 1 YEAR Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min. <b>56</b> |  | IF UNDER 24 HRS. Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min. <b>56</b>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Radio-Electric Mechanic</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Radio-Electric</b>  |  |   |  |
| 11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  |   |  |
| 13. FATHER'S NAME <b>William A. Hooper</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Laura Van Gosen</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO. <b>145-03-5858</b>   |  |   |  |
| 17. INFORMANT <b>Records</b>  |  |  |  | Address <b>Victor Cullen Hospital</b>  |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b> <b>002</b><br>DUE TO (b) <b>002 X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (c) <b>002</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>43 months</b> |  |  |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>0</b>  |  |  |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year <b>19</b><br>Hour a. m. <b>19</b> p. m. <b>19</b>  |  |  |  | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)        |  |
| 20f. (City or town) <b>19</b>   |  |  |  | (County) <b>19</b>   |  | (State) <b>19</b>   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3-17-58</b> to <b>7-16-61</b> , that (I) (we) last saw the deceased alive on <b>7-16-1961</b> , and that death occurred <b>2.30pm</b> from the causes and on the date stated above.  |  |  |  |  |  |   |  |
| 22a. SIGNATURE <b>Michael G. Zavis</b>  |  |  |  | 22b. DATE SIGNED <b>7-16-61</b>  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Michael G. Zavis</b>  |  |  |  | 22d. ADDRESS <b>Victor Cullen State Hospital; Cullen, Md.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE THEREOF <b>7-19-61</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Greenway</b>   |  | 23d. LOCATION (City, town, or county) (State) <b>Berkeley Springs, W. Va.</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Crager - Thummet Md</b>  |  |  |  | 25a. REC'D BY REGISTRAR <b>DATE JUL 18 '61</b>   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE <b>C. L. H. H. H.</b>  |  |  |  |  |  |   |  |

7018

CIRCUIT OF DEATH

(M)

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7973

07965

|   |                        |  |                                |
|---|------------------------|--|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Frederick MARYLAND   |                        | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE Maryland b. COUNTY Frederick                           |                                |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Myersville   |                        | c. LENGTH OF STAY in lb 6 hours  |                                |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route # 1  |                        | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                |
| 3. NAME OF DECEASED (Type or print) First ALVEY KEIFFER Last HOUP   |                        | 4. DATE OF DEATH Month July Day 1 Year 1961  |                                |
| 5. SEX male   | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 12, 1886 |
| 9. AGE (In years last birthday) 74 yrs.   |                        | IF UNDER 1 YEAR Months Days Hours Min.   |                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer   |                        | 10b. KIND OF BUSINESS OR INDUSTRY Gen. day farm labor  |                                |
| 11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.   |                        | 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |                                |
| 13. FATHER'S NAME Hiram Houpp   |                        | 14. MOTHER'S MAIDEN NAME Lydia Longman   |                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no   |                        | 16. SOCIAL SECURITY NO. 216-07-0763  |                                |
| 17. INFORMANT Mrs. Eva Houpp, Myersville, Md.   |                        | Address Rt. #2   |                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Arterio-Sclerosis<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                        | INTERVAL BETWEEN ONSET AND DEATH 15 min  |                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                        | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |                                |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19  |                        | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work   |                                |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                        | 20f. (City or town) (County) (State)   |                                |
| 21. I certify that (I) (this hospital) attended the deceased from July 1, 1961, to July 1, 1961, that (I) (we) last saw the deceased alive on July 1, 1961, and that death occurred at 4:45 PM, from the causes and on the date stated above.   |                        |  |                                |
| 22a. SIGNATURE J. Elmer Harp M.D.   |                        | 22b. DATE SIGNED   |                                |
| 22c. PHYSICIAN'S NAME (Type) J. Elmer Harp  |                        | 22d. ADDRESS Middle town Md  |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |                        | 23b. DATE THEREOF July 4, 1961   |                                |
| 23c. NAME OF CEMETERY OR CREMATORY Grossnickle's  |                        | 23d. LOCATION (City, town or county) (State) Nr. Myersville, Fred. Co. Md.   |                                |
| 24. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle   |                        | 25a. REC'D BY REGISTRAR DATE JUL 5 '61   |                                |
| ADDRESS Myersville, Md.   |                        | 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas  |                                |

37063

1973

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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7974 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07966

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Nr. Ridgeville</b>  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Damascus</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rt. # 144</b>   |  | d. STREET ADDRESS <b>Holsey Rd.</b>   |  |
| 3. NAME OF DECEASED (Type or print) <b>Lucille Helen Johnson</b>  |  | 4. DATE OF DEATH <b>July 29 1961</b>  |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>Colored</b>   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <b>Feb. 17, 1919</b>   |  |
| 9. AGE (In years last birthday) <b>42</b> yrs.  |  | 10. IF UNDER 1 YEAR Months Days   |  |
| 11. IF UNDER 24 HRS. Hours Min.   |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Pvt. homes</b>   |  |
| 11. BIRTHPLACE (State or foreign country) <b>Damascus, Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |
| 13. FATHER'S NAME <b>Robert Monroe</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Annie Zeigler</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>202-18-6387</b>  |  |
| 17. INFORMANT <b>Mrs Annie Cohens, Damascus, Md.</b>  |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gun shot wound of chest</b><br>DUE TO (b) <b>Thru heart</b><br>DUE TO (c) <b>Immediate</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).<br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Shot thru chest while leaving King's Tavern Route 144</b> |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>12:30 a.m.</b> <b>7/29 1961</b>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <b>Route 144</b>                          |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Nr Ridgeville</b>   |  | 20f. (City or town) <b>Frederick</b> (County) <b>Frederick</b> (State) <b>Md</b>  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE <b>B.D. Thomas</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type) <b>B.D. Thomas MD</b>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
| DATE SIGNED <b>July 29, 1961</b>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |
| Address (Street, city, town, or county)   |  | Address (Street, city, town, or county)   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>7/31/61</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Friendship Meth.</b>  |  | 22d. LOCATION (City, town, or country) <b>Damascus, Md.</b>   |  |
| 23. FUNERAL DIRECTOR <b>Oliver L. Mohrman</b>   |  | 24a. REC'D BY REGISTRAR <b>AUG 2 '61</b>  |  |
| Address <b>Damascus, Md.</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>   |  |

MEDICAL CERTIFICATION

(M)

(I)

St. Louis

St. Louis

St. Louis

St. Louis

St. Louis

St. Louis

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St. Louis

**LOCAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**FOR STATE  
HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>      |  | c. LENGTH OF STAY IN b.<br>Years<br><b>1615 Rosemont Avenue</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>CLARA</b>   |  | Middle<br><b>MARGARET</b>   |  | Last<br><b>JONES</b>  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House-work</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Frederick County</b>  |  |
| 13. FATHER'S NAME<br><b>George Crum</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Michael</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>Mr. G. Arthur Jones-Sameas</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>779X</b> <b>suffocation</b><br>DUE TO (b) <b>Plaster bag over head</b><br>DUE TO (c) <b>Plaster bag over head</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)               |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town)  |  | 20g. (County)   |  | 20h. (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>James B. Thomas</b>   |  | EXAMINER'S NAME (Type)<br><b>James B. Thomas, M.D.</b>  |  | DATE SIGNED<br><b>7/3/61</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>7-7-61</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>  |  |
| 22d. LOCATION (City, town, or country)   |  | 22e. (State)  |  | 22f. (County)   |  |
| 23. FUNERAL DIRECTOR<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |  | 23a. ADDRESS  |  | 23b. REC'D BY REGISTRAR<br><b>7/3/61</b>  |  |
| 23c. REGISTRAR'S SIGNATURE<br><b>Arthur S. House</b>   |  | 23d. (City, town, or country)   |  | 23e. (State)  |  |

THE STATE  
OF NEW YORK

(M)

(I)

Frederick

Frederick

1015 Broadway Avenue

CLARA

MARIE

JAMES

JOHN

White

Sept. 17, 1913

Home

Home-work

Frederick Company

George

Manager of Michael

No. 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

*Frederick*  
*White*

*Frederick*

James E. Thomas

1-7-13

Frederick, Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Reg. Dist. No.

07968

7978

|  |                              |   |   |   |  |  |                                      |
|--|------------------------------|---|---|---|--|--|--------------------------------------|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Frederick</u> MARYLAND  |                              |   |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> |  |  |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Johnsville</u>  |                              | c. LENGTH OF STAY IN 1b<br><u>15 yrs.</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Johnsville</u>   |  |  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                              |   |   | d. STREET ADDRESS<br><u>1</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>ELIZABETH</u> Middle <u>MAY</u> Last <u>KEENEY</u>  |                              |   |   | <b>4. DATE OF DEATH</b><br>Month <u>July</u> Day <u>27</u> Year <u>1961</u>   |  |  |                                      |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Jan. 27, 1893</u>  |   | 9. AGE (In years last birthday)<br><u>68</u> yrs.                      | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.                                 |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>own home</u>  |   | 11. BIRTHPLACE (State or foreign country)<br><u>New York</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>  |                                      |
| 13. FATHER'S NAME<br><u>Thomas E. McKeown</u>  |                              |   | 14. MOTHER'S MAIDEN NAME<br><u>Isabelle Jackson</u>   |   |  |  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>  |                              | 16. SOCIAL SECURITY NO.<br><u>-</u>   |   | 17. INFORMANT<br><u>Mr. Irven Long, Libertytown, Md.</u><br>Address   |  |  |                                      |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction + myocardial ischemia</u><br>DUE TO (b) <u>arteriosclerotic cardiovascular disease</u><br>DUE TO (c) <u>Hypertension, essential, benign, severe</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                              |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hours</u><br><u>15 years</u><br><u>20 years</u>      |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Paroxysmal right hemiplegia secondary to cerebral thrombosis</u>   |                              |   |   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |  |  |                                      |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><u>19</u>   |                              |   | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>August 19, 1960</u> to <u>27 July, 1961</u> , that I last saw the deceased alive on <u>26 July, 1961</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>Waldersville, Md.</u> DATE SIGNED <u>7/29/61</u>   |                              |   |   |   |  |  |                                      |
| ACTUAL SIGNATURE <u>James E. Stoner, Jr.</u> M.D.  |                              |   |   |   |  |  |                                      |
| PHYSICIAN'S NAME (Type) <u>JAMES E. STONER, Jr.</u>  |                              |   |   |   |  |  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |                              | 22b. DATE THEREOF   |   | 22c. NAME OF CEMETERY OR CREMATORY  |  | 22d. LOCATION (City, town, or county) (State)  |                                      |
| <u>Burial</u>  |                              | <u>7/30/61</u>  |   | <u>Rocky Hill Cem.</u>  |  | <u>W. Woodsboro Md.</u>  |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>G. C. Barton, Waldersville, Md.</u>   |                              |   |   | 24a. REC'D BY REGISTRAR<br>DATE <u>AUG 1 '61</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Clifford E. Hester</u>  |                                      |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7977

CERTIFICATE OF DEATH

07969

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Frederick</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>  |  | c. LENGTH OF STAY IN 1b <b>1/2 hr</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial</b>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <b>John Thomas</b>   |  | 4. DATE OF DEATH <b>July 26, 19 61</b>   |  |
| S. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | B. DATE OF BIRTH <b>May 15, 1891</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custom Work</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>For Farmers</b>   |  |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S?A.</b>   |  |
| 13. FATHER'S NAME <b>Phillip Keeney</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Barbara Ann Smith</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |  | 16. SOCIAL SECURITY NO. <b>220-34-5643</b>   |  |
| 17. INFORMANT <b>Irven T. Long</b>   |  | Address <b>Libertytown Md</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ruptured Abdominal Aneurysm, Arterio-sclerotic</b><br>451 X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular dis.</b><br>DUE TO (c) |  | INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Healed Anteroseptal Myocardial Infarct</b>  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above.   |  |  |  |
| 22a. SIGNATURE <b>Ernest A. Dettbarn</b> M.D.  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>July 28/61</b> |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. Ernest A. Dettbarn</b>   |  | 22d. ADDRESS <b>Walkersville, Maryland</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE THEREOF <b>7/30/1961</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Rocky Hill</b>   |  | 23d. LOCATION (City, town, or county) (State) <b>Rural Woodsboro Md</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>W. C. Barton, Walkersville, Md</b>   |  | ADDRESS  |  |
| 25a. REC'D BY REGISTRAR <b>AUG 1 '61</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>W. C. Barton</b>   |  |

M

1977

CENTROPHYLUS

03569

Frederick

Frederick

Frederick

Frederick

Frederick

Frederick

Frederick Memorial

Thomas

Thomas

Thomas

White

White

White

White

White

Philip Keeney

Philip Keeney

1977-1978

1977-1978

1977-1978

Arteriosclerotic cardiovascular disease  
Arteriosclerotic cardiovascular disease  
Arteriosclerotic cardiovascular disease

Heart and Arteriosclerotic Cardiovascular Disease

Dr. Ernest A. DeBorja

Dr. Ernest A. DeBorja

Dr. Ernest A. DeBorja

Dr. Ernest A. DeBorja

Dr. Ernest A. DeBorja

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7978

CERTIFICATE OF DEATH

07970

Item 9 film G291 7/21/61 jwk

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Frederick</b>       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sabillasville</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sabillasville</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Own Home</b>   |                                  | d. STREET ADDRESS<br><b>/</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>William Guy Kipe</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>July 16 19 61</b>  |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 18, 1901</b> |
| 9. AGE (In years last birthday)<br><b>60 59 yrs.</b>  |                                  | IF UNDER 1 YEAR<br>Months Days<br><b>1 2</b>  |  |
| IF UNDER 24 HRS.<br>Hours Min.<br><b>1 2</b>  |                                  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Butcher</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Cullen Hosp.</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>William H. Kipe</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Amanda V. Hardman</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>219-36-4860</b>   |  |
| 17. INFORMANT<br>Address<br><b>Hazel M. Kipe Sabillasville, Md.</b>   |                                  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adenocarcinoma of the esophagus</b><br><b>150X</b><br>DUE TO <b>c Metastases generalized</b><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1-2 yrs.</b>   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>19 May 1961</b> to <b>16 July 1961</b> , that (I) <del>last</del> saw the deceased alive on <b>14 July 1961</b> , and that death occurred at <b>8:50 A.M.</b> from the causes and on the date stated above.  |                                  |   |  |
| 22a. SIGNATURE<br><b>Harry H. Youngs, Jr.</b><br>M.D.   |                                  | 22b. DATE SIGNED<br><b>7-17-61</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Harry H. Youngs, Jr.</b>   |                                  | 22d. ADDRESS<br><b>Blue Ridge Summit, Penna.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>7-19-61</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Blue Ridge Cemetery</b>  |                                  | 23d. LOCATION (City, town or county) (State)<br><b>Thurmont, Md.</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Raymond E. Creagan</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>Thurmont, Md.</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>  |                                  | 25c. DATE<br><b>Jul 19 61</b>   |  |

VR A15 (4)  
15M 9/60

(M)

7077

Radcliffville, Kentucky  
Frederick  
Maryland  
Frederick  
Radcliffville, Kentucky  
Van Home

July 1, 1891  
White  
Butcher  
William B. Lipe  
Amos V. Newman  
U.S.A.  
No. 212-22-1140  
Hessell M. Lipe  
Radcliffville, Ky.

(1)

Henry H. Young, Jr.  
Blue Ridge Cemetery, Knoxville, Ky.  
Blue Ridge Cemetery, Knoxville, Ky.  
Thompson, Ky.  
7-12-01  
Thompson, Ky.



79798  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

079771

|  |                                  |   |                                      |  |   |  |   |
|--|----------------------------------|---|--------------------------------------|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  |   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                                  |   |                                      | c. LENGTH OF STAY IN 1b<br><b>40 years</b>   |   |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick Memorial Hospital</b>   |                                  |   |                                      | e. STREET ADDRESS<br><b>205 East Third Street</b>  |   |  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |                                      |  |   |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Susie</b> Middle <b>Carter</b> Last <b>Koontz</b>  |                                  |   |                                      | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>4</b> Year <b>19 61</b>   |   |  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-17-1874</b> |  | 9. AGE (In years last birthday)<br><b>87</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.                                    |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Carroll County, Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |   |
| 13. FATHER'S NAME<br><b>Henry Carter</b>   |                                  |   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Margaret E. Nicodemus</b>   |   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>212-14-6183D</b>  |                                      | 17. INFORMANT<br>Address<br><b>Mrs. Betty K. Young 205 E. 3rd St. Fred. Md.</b>  |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral infarction</b><br>332X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c) |                                  |   |                                      |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |                                      |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |  |   |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br>19  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>6/27</b> 19 <b>61</b> , to <b>7/4</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>7/3</b> 19 <b>61</b> , and that death occurred at <b>7:30</b> M, from the causes and on the date stated above.       |                                  |   |                                      |  |   |  |   |
| 22a. SIGNATURE<br><b>James B. Thomas</b>   |                                  |   |                                      | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                    |   | 22b. DATE SIGNED<br><b>7-5-61</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. James Thomas</b>  |                                  |   |                                      | 22d. ADDRESS<br><b>M.D. 228 North Market Street Frederick, Md.</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>7-6-1961</b>  |                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Linganor Church Cemetery</b>  |   | 23d. LOCATION (City, town, or county) (State)<br><b>Unionville, Maryland</b> |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert E. Dailey &amp; Son</b>  |                                  |   |                                      | ADDRESS<br><b>Frederick, Maryland</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 10 '61</b>                            |   |
|  |                                  |   |                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hunt</b>  |   |  |   |

M

I

MEDICAL CERTIFICATION

M

CHIEF OF BUREAU

07071

CERTIFICATE OF DEATH

1972

1. Name of deceased: [illegible]  
2. Date of death: [illegible]  
3. Place of death: [illegible]  
4. Cause of death: [illegible]  
5. Signature of physician: [illegible]  
6. Signature of registrar: [illegible]  
7. Date of registration: [illegible]  
8. Place of registration: [illegible]  
9. Name of registrar: [illegible]  
10. Name of physician: [illegible]  
11. Name of informant: [illegible]  
12. Address of informant: [illegible]  
13. Signature of informant: [illegible]  
14. Date of completion: [illegible]  
15. Place of completion: [illegible]  
16. Name of official: [illegible]  
17. Signature of official: [illegible]  
18. Date of issuance: [illegible]  
19. Place of issuance: [illegible]  
20. Name of issuer: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7980

CERTIFICATE OF DEATH

07972

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>             |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>Lifetime</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick Memorial Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>311 South Market Street</b>  |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lydia</b> Middle <b>Ellen</b> Last <b>Lee</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>12</b> Year <b>19 61</b>  |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>9-12-1881</b>   |  |
| 9. AGE (In years lost birthday)<br><b>79</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Practical Nurse</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Frederick Co., Maryland</b>          |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>William L. W. Lee</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Susan Ball</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>218-34-3533A</b>   |  | 17. INFORMANT<br>Address<br><b>Mr. Denver Shook 311 S. Market St. Frederick, Md.</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>acute myocardial infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1-2 days</b>  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  |   | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 11, 1961</b> to <b>July 12, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 12, 1961</b> , and that death occurred at <b>5:42 PM</b> , from the causes and on the date stated above.  |  |   |  |  |  |  |  |
| 22a. SIGNATURE<br><b>Dr. N. G. Goodman</b>  |  |   |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                |  | 22b. DATE SIGNED   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. N. G. Goodman</b>  |  |   |  | 22d. ADDRESS<br><b>M.D. 810 Toll House Avenue Fred. Md.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>7-15-1961</b>     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Frederick Memorial Park</b>   |  | 23d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b>          |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert E. Dailey &amp; Son</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>Frederick, Maryland</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>DATE JUL 18 '61</b>                                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7981

CERTIFICATE OF DEATH

07973

|   |                               |  |  |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>   |                               | c. LENGTH OF STAY IN 1b <b>4 days</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>  |                               | e. STREET ADDRESS <b>Lantz P.O.</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Arby</b> Middle <b>Roy</b> Last <b>MANAHAN</b>  |                               | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>29</b> Year <b>1961</b>   |  |
| 5. SEX <b>male</b>  | 6. COLOR OR RACE <b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Sept. 24, 1884</b> |
| 9. AGE (In years last birthday) <b>76</b> yrs.  |                               | 10. IF UNDER 1 YEAR: Months <b>7</b> Days <b>29</b> Hours <b>19</b> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>Daniel Manahan</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Amanda Buhrman</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO. <b>None</b>  |  |
| 17. INFORMANT <b>Leo Manahan</b>  |                               | Address <b>Lantz, Md.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>GENERALIZED ARTERIOSCLEROSIS</b><br>DUE TO<br>(c) _____ |                               | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b><br><b>about 10 years</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7/24</b> <b>1961</b> to <b>7/29</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>7/28</b> <b>1961</b> , and that death occurred at <b>1:00</b> <b>A</b> . M, from the causes and on the date stated above.  |                               |  |  |
| 22a. SIGNATURE <b>Richard C. Reynolds,</b> M.D.   |                               | 22b. DATE SIGNED <b>8/1/61</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Richard C. Reynolds</b>   |                               | 22d. ADDRESS <b>9 E. Church St. Frederick, Md.</b>   |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>  |                               | 23b. DATE THEREOF <b>8-1-61</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Moriah Cem.</b>   |                               | 23d. LOCATION (City, town, or county) (State) <b>Foxville Fred. Co. Md.</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Guager</b>   |                               | ADDRESS <b>Thurmont, Md.</b>   |  |
| 25a. REC'D BY REGISTRAR <b>AUG 3 '61</b>  |                               | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>  |  |



1981

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7982  
CERTIFICATE OF DEATH

07974

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b><br>c. LENGTH OF STAY IN 1b<br><b>40 years</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>408 W. Patrick Street, Frederick, Md.</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Frederick</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b><br>d. STREET ADDRESS<br><b>408 W. Patrick St. Frederick, Md.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Minnie</b><br>First<br><b>Rosalie</b><br>Middle<br><b>Milyard</b><br>Last   |  | 4. DATE OF DEATH<br><b>July</b><br>Month<br><b>24</b><br>Day<br><b>1961</b><br>Year   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>October 5, 1874</b>  |  |
| 9. AGE (In years last birthday)<br><b>86</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Housewife</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Middleburg, Maryland.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>George Biehl</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Penelope Miller</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |
| 17. INFORMANT<br><b>John W. Milyard, Thurmont, Route #1.</b>   |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br>DUE TO (b) <b>Nephritis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <b>Cardiovascular</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>6 days</b><br><b>2 yrs +</b><br><b>5 yrs +</b> |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b><br>20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> to <b>July 24, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 23, 1961</b> , and that death occurred at <b>2:00</b> AM, from the causes and on the date stated above.   |  |   |  |
| 22a. SIGNATURE<br><b>B.O. Thomas</b><br>M.D.<br>22c. PHYSICIAN'S NAME (Type)<br><b>B.O. Thomas, Sr.</b>  |  | 22b. DATE SIGNED<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22d. ADDRESS<br><b>228 N. Market St. Frederick, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>July 26, 1961</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Frederick, Maryland.</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>M.R. Etchison &amp; Son, 106 E. Church St. Frederick, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>JUL 26 '61</b><br>25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Thomas</b>   |  |

07074

7222

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Frederick, 40 years, 5' 10", 150 lbs., brown hair, blue eyes, single, no children.

Frederick, 40 years, 5' 10", 150 lbs., brown hair, blue eyes, single, no children.

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Frederick, 40 years, 5' 10", 150 lbs., brown hair, blue eyes, single, no children.

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician. Part 2 may be retained by the funeral director. Part 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7983

07975

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY<br><b>Frederick</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Nr. Lander</b><br>c. LENGTH OF STAY IN 1b<br><b>5 years</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Glen Merrie Nursing Home</b>                    |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Frederick</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b><br>d. STREET ADDRESS<br><b>521 Wilson Place</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><b>Carlton</b>   |  | <b>4. DATE OF DEATH</b><br>Month<br><b>July</b><br>Day<br><b>25</b><br>Year<br><b>19 61.</b>                     |  |   |  |  |  |
| <b>5. SEX</b><br><b>Male</b>  |  | <b>6. COLOR OR RACE</b><br><b>White</b>  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |
| <b>8. DATE OF BIRTH</b><br><b>February 15, 1876</b>   |  | <b>9. AGE (in years last birthday)</b><br><b>85</b> yrs.   |  | <b>10. IF UNDER 1 YEAR</b><br>Months<br><b>85</b> Days<br><b>19</b> Hours<br><b>61</b> Min.   |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Prof. Ballplayer</b>   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>Baseball</b>  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>Frederick County.</b>  |  |  |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>  |  | <b>13. FATHER'S NAME</b><br><b>Thomas Molesworth</b>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Drucilla Browning</b>   |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>   |  | <b>16. SOCIAL SECURITY NO.</b><br><b>206-01-1236</b>   |  | <b>17. INFORMANT</b><br><b>Carlton Molesworth, Jr.</b>  |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY,<br>IMMEDIATE CAUSE (a)<br><b>331X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO<br>(b) <b>Cerebral hemorrhage</b><br>(c) <b>Generalized arteriosclerosis</b> |  | <b>19. INTERVAL BETWEEN ONSET AND DEATH</b><br><b>days</b><br><b>years</b>                                       |  |   |  |  |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>  |  |  |  |   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour e.m.<br>p.m.<br><b>19</b>  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not White at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  |  |  |
| <b>20f. (City or town)</b><br><b>Frederick</b>  |  | <b>20g. (County)</b><br><b>Frederick</b>   |  | <b>20h. (State)</b><br><b>Md.</b>   |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from..... 1947 to..... 7/25, 1961, that (I) (we) last saw the deceased alive on..... 7/24..... 1961, and that death occurred at..... 12:30 P.M., from the causes and on the date stated above.</b>  |  |  |  |   |  |  |  |
| <b>22a. SIGNATURE</b><br><b>James B. Thomas</b>   |  | <b>22b. DATE SIGNED</b><br><b>7/28/61</b>  |  |   |  |  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><b>James B. Thomas, M.D.</b>   |  | <b>22d. ADDRESS</b><br><b>228 N. Market St. Frederick, Md.</b>   |  |   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>   |  | <b>23b. DATE THEREOF</b><br><b>7/28/61</b>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Mount Olivet Cemetery</b>   |  |  |  |
| <b>23d. LOCATION (City, town or county)</b><br><b>Frederick, Maryland.</b>  |  |  |  |   |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>M.R. Etchison &amp; Son, 106 E. Church St. Frederick, Md.</b>   |  | <b>25a. REC'D BY REGISTRAR</b><br><b>JUL 31 '61</b>  |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Carlton B. Thomas</b>   |  |  |  |

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John Martin Martinson  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7984

CERTIFICATE OF DEATH

07976

|  |                              |   |  |
|--|------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick Memorial Hospital</u><br><u>Frederick Co</u><br>MARYLAND   |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>CARROLL</u> ✓                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Frederick</u>   |                              | c. LENGTH OF STAY IN 1b<br><u>5 days</u>  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Keymar</u>  |                              | d. STREET ADDRESS<br><u>06x-1</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Frederick Memorial Hospital</u>   |                              | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>MARIAN</u> Middle <u>T</u> Last <u>OTTO</u>  |                              | 4. DATE OF DEATH<br>Month <u>JULY</u> Day <u>27</u> Year <u>1961</u>  |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>NOV 30 1882</u> |
| 9. AGE (In years last birthday)<br><u>78</u> yrs.  |                              | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House Wife</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>MD</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Frederick Co</u>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><u>US</u>   |  |
| 13. FATHER'S NAME<br><u>JAMES W. TROXELL</u>   |                              | 14. MOTHER'S MAIDEN NAME<br><u>MARY ELIZABETH ZOCHORIAN</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>(If yes, give war or dates of service)</u>  |                              | 16. SOCIAL SECURITY NO.<br><u>Col. THOMAS W. OTTO</u>   |  |
| 17. INFORMANT<br><u>Address Fort Shafter Honolulu Hawaii</u>   |                              |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBRO VASCULAR ACCIDENT</u><br>DUE TO <u>331X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>GENERALIZED ARTERIOSCLEROSIS</u><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>ATRIAL FIBRILLATION</u> |                              | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 days</u><br><u>10+ years</u>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                              | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>    |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6/1</u> 19 <u>61</u> , to <u>7/26</u> 19 <u>61</u> , that <u>0</u> (we) last saw the deceased alive on <u>7/26</u> 19 <u>61</u> , and that death occurred at <u>3:5</u> AM, from the causes and on the date stated above.   |                              |   |  |
| 22a. SIGNATURE<br><u>Richard C. Reynolds</u>   |                              | 22b. DATE<br><u>7/27/61</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Raymond K. Wright</u>   |                              | 22d. ADDRESS<br><u>Union Bridge MD</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                              | 23b. DATE THEREOF<br><u>July 29-61</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>MT ZION Mthw's Church</u>   |                              | 23d. LOCATION (City, town, or county) (State)<br><u>Keymar MD</u>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>RAYMOND K. WRIGHT</u>   |                              | 25a. REC'D BY REGISTRAR<br><u>Jul 31 '61</u>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Freund</u>  |                              |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7985  
CERTIFICATE OF DEATH  
07977

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Myersville</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>life</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                  | d. STREET ADDRESS<br><b>Rural Myersville</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Tabitha</b> Middle <b>V.</b> Last <b>Palmer</b>   |                                  | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>11</b> Year <b>19 61</b>  |  |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9/4/1877</b>                                    |
| 9. AGE (In years last birthday)<br><b>83</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>           |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |                                  | 13. FATHER'S NAME<br><b>Josephus Palmer</b>   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Manzella Rice</b>  |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>                                      |  |
| 16. SOCIAL SECURITY NO.<br><b>none</b>  |                                  | 17. INFORMANT<br>Address<br><b>Mrs. George R. Markern, Myersville, Md.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Renal Devascular Disease</b><br><b>442X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 yrs</b>                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town)<br><b>Jan 1955 to July 11 1961</b>  |                                  | 20g. (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1955</b> to <b>July 11 1961</b> , that (I) (we) last saw the deceased alive on <b>July 2 1961</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above.  |                                  |   |  |
| 22a. SIGNATURE<br><b>Dr. J. Elmer Harp</b>  |                                  | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. J. Elmer Harp</b>  |                                  | 22d. ADDRESS<br><b>Middletown, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  |                                  | 23b. DATE THEREOF<br><b>7/14/1961</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lutheran Cemetery</b>  |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Wolfsville, Md.</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Gladhill Company, Middletown, Md.</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>JUL 17 '61</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kneass</b>   |                                  |   |  |

1907

CERTIFICATE OF DEATH

1907



Blank form with horizontal lines for text entry.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1

7985

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07978

|  |   |   |   |
|--|---|---|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Frederick</u> <u>MARYLAND</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Middletown</u><br>c. LENGTH OF STAY IN 1b <u>40 years</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1</u>   |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Middletown</u><br>d. STREET ADDRESS <u>1</u> |   |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>Mary</u> Middle <u>Susan</u> Last <u>Poole</u>  |   | <b>4. DATE OF DEATH</b><br>Month <u>7</u> Day <u>28</u> Year <u>1961</u>  |   |
| <b>5. SEX</b><br><u>female</u>   | <b>6. COLOR OR RACE</b><br><u>white</u> | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | <b>8. DATE OF BIRTH</b><br><u>2/2/1886</u>                                    |
| <b>9. AGE</b> (In years last birthday) <u>75</u> yrs.  |   | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>   | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Maryland</u> |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.</u>   |   | <b>13. FATHER'S NAME</b><br><u>Daniel L. Bussard</u>  |   |
| <b>14. MOTHER'S MAIDEN NAME</b><br><u>Mary M. Cline</u>  |   | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)<br><u>no</u>  |   |
| <b>16. SOCIAL SECURITY NO.</b><br><u>none</u>  |   | <b>17. INFORMANT</b> Address<br><u>Daniel C. Poole, Jefferson, Md.</u>  |   |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Mesenteric Thrombosis</u><br>DUE TO <u>Generalized Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>and Arteriosclerotic Heart Disease</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>14 1/2 hrs</u><br><u>unknown</u><br><u>6 wks.</u> |   |   |   |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |   |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   |   |   |
| <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |
| <b>20c. TIME OF INJURY</b><br>Hour a.m. p.m. <u>19</u>   |   | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |   | <b>20f. (City or town) (County) (State)</b>   |   |
| <b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>7/5</u> 19 <u>59</u> to <u>7/28</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/27</u> 19 <u>61</u> , and that death occurred at <u>7:30</u> AM, from the causes and on the date stated above.  |   |   |   |
| <b>22a. SIGNATURE</b><br><u>Kenneth C. Henson</u> M.D.   |   | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>7/28/61</u><br><b>22b. DATE SIGNED</b>  |   |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Kenneth C. Henson, MD</u>  |   | <b>22d. ADDRESS</b><br><u>2 Linden Blvd. Middletown, Md.</u>  |   |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>burial</u>  |   | <b>23b. DATE THEREOF</b><br><u>7/30/1961</u>  |   |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Lutheran Cemetery</u>  |   | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Middletown, Md.</u>   |   |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Gladhill Company, Middletown, Md.</u>  |   | <b>25a. REC'D BY REGISTRAR</b><br><u>JUL 31 '61</u>   |   |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Henson</u>   |   |   |   |

07078

3888



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7987  
CERTIFICATE OF DEATH  
07979

|  |                                  |  |                                       |   |   |   |
|--|----------------------------------|--|---------------------------------------|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b><br>c. LENGTH OF STAY IN 1b<br><b>MARYLAND</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>201 South Market Street</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Frederick</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b><br>d. STREET ADDRESS <b>201 South Market Street</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                       |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JAMES</b> Middle <b>GROVE</b> Last <b>POWELL</b>   |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>3</b> Year <b>1961</b>  |                                       |   |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>6 Dec 1902</b> | 9. AGE (In years last birthday)<br><b>58</b> yrs.                         | IF UNDER 1 YEAR<br>Months <b>58</b> Days <b>0</b> | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b>                          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired-Conductor</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>   |                                       | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>    |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                |
| 13. FATHER'S NAME<br><b>Roy G. Powell</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Emma Jane Redmond</b>   |                                       |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |                                       | 17. INFORMANT<br>Address<br><b>Mrs. Grace A. Powell (Same as item #1)</b> |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cornary Thrombosis</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic Heart Disease</b><br>(c) <b>6 months</b><br>DUE TO<br>(e), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>Instant</b> |                                  |  |                                       |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |   |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)    |   | 20f. (City or town) (County) (State)                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>5-15</b> 19 <b>61</b> , to <b>7-3</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>July 3</b> 19 <b>61</b> , and that death occurred at <b>10A</b> M, from the causes and on the date stated above.   |                                  |  |                                       |   |   |   |
| 22a. SIGNATURE<br><b>Thomas E. Stone</b><br>M.D.   |                                  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |                                       | 22b. DATE<br><b>5 July 1961</b>   |   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Thomas E. Stone, M. D.</b>  |                                  | 22d. ADDRESS<br><b>4 W. Third St., Frederick, Md.</b>  |                                       |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>7-6-61</b>   |                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Bethel Cemetery</b>          |   | 23d. LOCATION (City, town or county) (State)<br><b>Garfield, Maryland</b> |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |                                  | ADDRESS  |                                       | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 7 '61</b>                          |   | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>                      |

24



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

# CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7988

## CERTIFICATE OF DEATH

07980

|  |                               |   |                                       |
|--|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>FREDERICK</b> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>  |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>   |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL HOSPITAL</b>  |                               | d. STREET ADDRESS <b>1606 LEE PLACE</b>   |                                       |
| 3. NAME OF DECEASED (Type or print) First <b>GERARD</b> Middle <b>—</b> Last <b>PUTNAM</b>   |                               | 4. DATE OF DEATH Month <b>July</b> Day <b>22</b> Year <b>1961</b>   |                                       |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>July 20, 1961</b> |
| 9. AGE (In years lost birthday) yrs. <b>2</b>  |                               | 10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>  |                                       |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |                                       |
| 13. FATHER'S NAME <b>Charles Soyerbu Putnam Jr</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Kathryn ANN Karitas</b>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO. <b>None</b>   |                                       |
| 17. INFORMANT <b>Mother</b>  |                               | Address   |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Immature infant</b><br><b>776X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b><br>DUE TO (c) <b>—</b> |                               | INTERVAL BETWEEN ONSET AND DEATH <b>36 hr</b>   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>   |                               | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>   |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>—</b> 19 <b>—</b><br>p. m. <b>—</b>  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>  |                               | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7-20</b> 19 <b>61</b> , to <b>7-22</b> 19 <b>61</b> , that (I) <b>we</b> last saw the deceased alive on <b>7-22</b> 19 <b>61</b> , and that death occurred at <b>5 AM</b> , from the causes and on the date stated above.                         |                               |   |                                       |
| 22a. SIGNATURE <b>Charles E Wright M.D.</b>  |                               | 22b. DATE SIGNED  |                                       |
| 22c. PHYSICIAN'S NAME (Type) <b>Charles E. Wright M.D.</b>   |                               | 22d. ADDRESS <b>Fred Podolski Cent</b>  |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 23b. DATE THEREOF <b>7-24-61</b>  |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>  |                               | 23d. LOCATION (City, town, or county) (State) <b>Frederick Maryland</b>   |                                       |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison and Son, Frederick, Maryland</b>  |                               | 25a. REC'D BY REGISTRAR <b>Jul 25 '61</b>   |                                       |
| 25b. REGISTRAR'S SIGNATURE <b>Charles E. Knows</b>   |                               |   |                                       |

2069295 XVO



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7989

CERTIFICATE OF DEATH

07981

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> ✓                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural-- Mt Airy</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick Memorial Hospital</b>   |                                  | d. STREET ADDRESS<br><b>R. D. # 3</b> <b>06X-2</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Minnie</b> Middle <b>A.</b> Last <b>ROACH</b>  |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>27</b> Year <b>19 61</b>   |   |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 25, 1881</b> 79 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Domestic</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   |
| 13. FATHER'S NAME<br><b>Thomas Fogle</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Annie Ross</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No.</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>No.</b>   |   |
| 17. INFORMANT<br><b>Mrs. Albert C. Smith, Same as 2</b>  |                                  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebro-vascular thrombosis, recurrent</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Atrial fibrillation</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 weeks</b><br><b>20 years</b>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>    |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 15, 1957</b> to <b>July 27, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 26, 1961</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.   |                                  |   |   |
| 22a. SIGNATURE<br><b>Ralph L. Michels</b>  |                                  | 22b. DATE SIGNED<br><b>July 27, 61</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Ralph L. Michels</b>  |                                  | 22d. ADDRESS<br><b>Shopping Center, Frederick, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>July 29, 1961</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sams Creek Brethren</b>   |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Carroll Co., Maryland</b>   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>C. M. Waltz,</b>  |                                  | 24. ADDRESS<br><b>Winfield, Maryland</b>  |   |
| 25a. REC'D BY REGISTRAR<br><b>JUL 31 '61</b>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>William D. Turner</b>  |   |

11587

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7990  
CERTIFICATE OF DEATH  
07982

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Thurmont</b><br>c. LENGTH OF STAY IN 1b <b>Lifetime</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>at his home</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MD</b><br>b. COUNTY <b>Frederick</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Thurmont</b><br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HARRY</b> Middle <b>JOSEPH</b> Last <b>RODGERS</b>  |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>3</b> Year <b>1961</b>  |   |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>Oct. 23. 1885</b>                 |
| 9. AGE (In years last birthday) <b>75</b> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>5</b>   | 11. IF UNDER 24 HRS.<br>Hours <b>7</b> Min. <b>30</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Hoke Wood Prod.</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Near Thurmont.Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>  |   |
| 13. FATHER'S NAME <b>Samuel Wesley Rodgers</b>  |   | 14. MOTHER'S MAIDEN NAME <b>Annie S. Nail</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |   | 16. SOCIAL SECURITY NO. <b>213-18-0702</b>   |   |
| 17. INFORMANT<br>Address <b>Carrie B. Rodgers Thurmont.R.D.I MD</b>   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Genl advanced Arteriosclerosis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <b>No</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 hours</b><br><b>20 yrs</b>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year <b>7/2/61</b><br>Hour a.m. <b>9:30A</b> p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7/2/61</b> to <b>7/3/61</b> , 19 <b>61</b> , that (we) last saw the deceased alive on <b>7-2-61</b> , 19 <b>61</b> , and that death occurred at <b>7/3/61</b> , from the causes and on the date stated above.  |   |  |   |
| 22a. SIGNATURE <b>Thomas A. Love</b>  |   | 22b. DATE SIGNED   |   |
| 22c. PHYSICIAN'S NAME (Type) <b>Thomas A. Love</b>  |   | 22d. ADDRESS <b>Thurmont. MD.</b>  |   |
| 23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>  |   | 23b. DATE THEREOF <b>July.7.1961</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY <b>United Brethern Cem.</b>  |   | 23d. LOCATION (City, town or county) (State) <b>Thurmont.Fredk.Co.Md</b>   |   |
| 24. REGISTRAR'S SIGNATURE <b>Raymond B. Greager</b>   |   | 25a. REC'D BY REGISTRAR <b>JUL 10 1961</b>   |   |
| ADDRESS <b>Thurmont. MD</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7991  
CERTIFICATE OF DEATH

07983

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|--|---|---|---|
| 1. PLACE OF DEATH<br>e. COUNTY <b>Frederick</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>e. STATE <b>Maryland</b><br>b. COUNTY <b>Frederick</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#1</b><br>d. STREET ADDRESS <b>Gashouse Pike</b><br>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>PHEBE</b> Middle <b>CRAMER</b> Last <b>ROUTZHAN</b>  |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>2</b> Year <b>1961</b>   |   |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>28 April 1868</b>                                   |
| 9. AGE (In years last birthday) <b>93</b> yrs  |   | 10. IF UNDER 1 YEAR Months Days<br>IF UNDER 24 HRS. Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>  | 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>     |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   | 13. FATHER'S NAME <b>Edward Cramer</b>  |   |
| 14. MOTHER'S MAIDEN NAME <b>Sarah Hyder</b>  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>   |   |
| 16. SOCIAL SECURITY NO. <b>None</b>  |   | 17. INFORMANT Address <b>Harry C. Routzhan (Same as item #2)</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b><br>420.1 DUE TO <b>Arterio-sclerotic Cardio-vascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>20 years</b> |   | INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <b>March 15, 1959</b> to <b>July 2, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 2, 1961</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE <b>Bernard O. Thomas Jr.</b> M.D.   |   | 22b. DATE SIGNED <b>5 July 1961</b>   |   |
| 22c. PHYSICIAN'S NAME (Type) <b>Bernard O. Thomas, Jr., M. D.</b>  |   | 22d. ADDRESS <b>228 N. Market St., Frederick, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 23b. DATE THEREOF <b>7-5-61</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>   | 23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>  |   | 25a. REC'D BY REGISTRAR <b>JUL 7 '61</b><br>DATE<br>25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>   |   |

1927

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7992

CERTIFICATE OF DEATH

07984

|   |                                  |  |                                      |
|---|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>   |                                      |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Brunswick</b>  |                                  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Brunswick</b>   |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>730 Park Avenue</b>  |                                  | d. STREET ADDRESS<br><b>730 Park Avenue</b>  |                                      |
| 3. NAME OF DECEASED (Type or print)<br><b>John Wesley Seay</b>  |                                  | 4. DATE OF DEATH<br><b>7 30 19 61</b>  |                                      |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>7-23-1883</b> |
| 9. AGE (In years last birthday)<br><b>78</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>30</b> Hours <b>19</b> Min. <b>61</b>   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Methodist Minister</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>   |                                      |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>U.S.A.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                      |
| 13. FATHER'S NAME<br><b>John W. Seay</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Rebecca Patten</b>  |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Mrs. Minnie Seay, Brunswick, Maryland</b>  |                                      |
| 17. INFORMANT<br><b>Mrs. Minnie Seay, Brunswick, Maryland</b>   |                                  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>Rectum-Carcinoma</b><br>DUE TO<br>(c) <b>Carcinomatosis</b> |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>4 mon.</b><br><b>1 mon.</b>  |                                      |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m. p.m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 2, 1960</b> to <b>July 30, 1961</b> that (I) (we) last saw the deceased alive on <b>July 30, 1961</b> , and that death occurred at <b>4:35 A.M.</b> , from the causes and on the date stated above. |                                  |  |                                      |
| 22a. SIGNATURE<br><b>C.T. Byron Kao</b>   |                                  | 22b. DATE SIGNED<br><b>July 31, 1961</b>   |                                      |
| 22c. PHYSICIAN'S NAME (Type)<br><b>C.T. Byron Kao, M.D.</b>   |                                  | 22d. ADDRESS<br><b>Gum Spring Hollow Brunswick, Md.</b>  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>8-1-1961</b>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Millsboro</b>  |                                  | 23d. LOCATION (City, town or county) (State)<br><b>Millsboro, Virginia</b>   |                                      |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John F. Felt</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>DATE AUG 4 '61</b>   |                                      |
| ADDRESS<br><b>Brunswick, Maryland</b>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>William S. Pinner</b>   |                                      |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item 8 Film 0292 7/31/61 1vk

7993

07985

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Rural Middletown</b><br>c. LENGTH OF STAY IN 1b<br><b>40 years</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Frederick</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Rural Middletown</b><br>d. STREET ADDRESS<br><b>1</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Alice A. Shafer</b>   |                                  | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>23</b> Year <b>1961</b>   |  |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>11/20/1895</b>                                  |
| 9. AGE (In years last birthday)<br><b>65</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>24</b>   | 11. IF UNDER 24 HRS.<br>Hours <b>24</b> Min.                           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |                                  | 13. FATHER'S NAME<br><b>Charles H. Shafer</b>   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Ella Koogle</b>   |                                  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |  |
| 16. SOCIAL SECURITY NO.<br><b>none</b>   |                                  | 17. INFORMANT<br><b>Lunzie T. Shafer, Middletown, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>420.1</b> DUE TO<br><b>Coronary Occlusion</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b)<br><b>Coronary Sclerosis</b><br>DUE TO (c)<br><b>24</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 m</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>Arterio Sclerosis - Bronchitis</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)  |  |
| 20c. TIME OF INJURY<br>Hour a.m. <b>19</b> p.m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town)<br><b>Jefferson, Md.</b>   |                                  | (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7/15 1961</b> to <b>7/23 1961</b> that (I) (we) last saw the deceased alive on <b>7/20 1961</b> and that death occurred at <b>11:45 A.M.</b> from the causes and on the date stated above.  |                                  |   |  |
| 22a. SIGNATURE<br><b>Dr. A. Talbott Brice</b>  |                                  | 22b. DATE SIGNED<br><b>7/23/61</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. A. Talbott Brice</b>  |                                  | 22d. ADDRESS<br><b>Jefferson, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>7/26/1961</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lutheran Cemetery</b>         |
| 23d. LOCATION (City, town or county)<br><b>Middletown, Md.</b>   |                                  | (State)   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Gladhill Company, Middletown, Md.</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>DATE JUL 26 '61</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hanna</b>   |                                  |   |  |

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*[Faint, illegible text, possibly bleed-through from the reverse side of the page]*



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7994

## CERTIFICATE OF DEATH

07986

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>1 week</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick Memorial Hosptal</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Charles</b> Middle <b>E</b> Last <b>Shank</b>  |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>17</b> Year <b>19 61</b>   |   |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 26, 1912</b> |
| 9. AGE (In years last birthday)<br><b>49</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>17</b> Hours <b>19</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Park Manager</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Cat. Nat'l. Park</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Penna.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Wilbur E. Shank</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary E. Jones</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>WW 11 578-01-3786</b>   |   |
| 17. INFORMANT<br><b>Mrs. Mary E. Shank</b>   |                                  | Address<br><b>Thurmont, Md. RD</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute pancreatitis</b><br><b>540.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Benign duodenal ulcer</b><br>DUE TO (c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 days</b><br><b>9 yrs</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19 p. m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>10 July 1961</b> to <b>17 July 1961</b> , that (I) (we) lost saw the deceased alive on <b>17 July 1961</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.   |                                  |   |   |
| 22a. SIGNATURE<br><b>Melvin E. Lea M.D.</b>  |                                  | 22b. DATE SIGNED<br><b>18 July 1961</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Melvin E. Lea M.D.</b>  |                                  | 22d. ADDRESS<br><b>Medical Center, Frederick, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>7-21-61</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Natl. Cem.</b>  |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Arlington, Virginia</b>   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Raymond E. Egan</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>Thurmont, Md.</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kline</b>   |                                  | 25c. DATE<br><b>JUL 24 '61</b>  |   |

MEDICAL CERTIFICATION

1988

INVESTIGATION OF DEATH

1988



Investigation of Death  
Name: [illegible]  
Date of Death: [illegible]  
Place of Death: [illegible]  
Cause of Death: [illegible]  
Manner of Death: [illegible]  
Medical History: [illegible]  
Social History: [illegible]  
Family History: [illegible]  
Autopsy: [illegible]  
Toxicology: [illegible]  
Microbiology: [illegible]  
Histology: [illegible]  
Radiology: [illegible]  
Laboratory: [illegible]  
Signature: [illegible]  
Date: [illegible]

[illegible text block containing various notes and signatures]

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 7995 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07987

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FOR STATE HEALTH DEPT.  
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TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |   |  |  |  |   |  |  |  |                                     |  |  |  |                             |  |                             |  |
|--|--|---|--|--|--|---|--|--|--|-------------------------------------|--|--|--|-----------------------------|--|-----------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b><br>c. LENGTH OF STAY IN b <b>30 years</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>325 Braddock Avenue</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Frederick</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b><br>d. STREET ADDRESS <b>325 Braddock Ave.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |                                     |  |  |  |                             |  |                             |  |
| 3. NAME OF DECEASED (Type or print) <b>Raymond Franklin Shultz</b>   |  | 4. DATE OF DEATH <b>July 21</b> Day <b>19</b> Year <b>61</b>  |  | 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>May 2, 1905</b> |  | 9. AGE (In years last birthday) <b>56</b> yrs. |  | IF UNDER 1 YEAR Months Days |  | IF UNDER 24 HRS. Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector of brushes</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Brush factory</b>   |  |   |  | 11. BIRTHPLACE (State or foreign country) <b>Frederick Co.</b>   |  |                                     |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>     |  |                             |  |                             |  |
| 13. FATHER'S NAME <b>Charles Shultz</b>  |  |   |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Della Gaver</b>   |  |  |  |                                     |  |  |  |                             |  |                             |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO. <b>214-10-2774</b>   |  |   |  | 17. INFORMANT Address <b>Mrs. Eva Shultz, 325 Braddock Ave, Frederick</b>  |  |                                     |  |  |  |                             |  |                             |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>4204<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(e), stating the underlying cause last. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |   |  |  |  |                                     |  |  |  |                             |  |                             |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |  |                                     |  |  |  |                             |  |                             |  |
| 20c. TIME OF INJURY<br>Hour e.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |  |  |                                     |  |  |  |                             |  |                             |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |   |  |  |  |   |  |  |  |                                     |  |  |  |                             |  |                             |  |
| ACTUAL SIGNATURE <b>B.O. Thomas</b>  |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  | DATE SIGNED <b>July 21, 1961</b>   |  |                                     |  |  |  |                             |  |                             |  |
| EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  | Address (Street, city, town, or county)  |  |                                     |  |  |  |                             |  |                             |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>7-21-1961</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Grossnickle Church Cemetery</b>  |  | 22d. LOCATION (City, town, or country) (State) <b>Ellerton, Fred. Co., Maryland</b> |  |  |  |                                     |  |  |  |                             |  |                             |  |
| 23. FUNERAL DIRECTOR <b>Robert E. Dailey &amp; Son</b>   |  |   |  | 24a. REC'D BY REGISTRAR <b>Robert E. Dailey</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>Robert E. Dailey</b>                                  |  |  |  |                                     |  |  |  |                             |  |                             |  |
| VS. A1SME SM 7/59  |  |   |  | DATE <b>JUL 26 '61</b>   |  |   |  |  |  |                                     |  |  |  |                             |  |                             |  |

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Inspector

Inspector

Inspector

Inspector

50 years

Inspector

Inspector

Inspector

Inspector

Inspector

Inspector

White

May 5, 1907

Inspector of Prisoners

Inspector of Prisoners

Charles Smith

John Dwyer

No

Coroner's Commission

P.O. Thomas, N.Y.

May 21, 1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7995

CERTIFICATE OF DEATH

07988

Item 23 Film 0292 7/31/61 1wk

|  |                             |  |                                   |
|--|-----------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cullen</b>   |                             | c. LENGTH OF STAY IN 1b <b>140 days</b>  |                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Victor Cullen State Hospital</b>   |                             | d. STREET ADDRESS <b>171 W. Main Street</b>  |                                   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>James</b> Middle <b>Ozark</b> Last <b>Sipes</b>  |                             | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>24</b> Year <b>1961</b>   |                                   |
| 5. SEX <b>M.</b>   | 6. COLOR OR RACE <b>Wh.</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>5-20-1886</b> |
| 9. AGE (In years last birthday) <b>75</b> yrs.   |                             | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>  |                             | 10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture Store</b>   |                                   |
| 11. BIRTHPLACE (State or foreign country) <b>Missouri</b>  |                             | 12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>  |                                   |
| 13. FATHER'S NAME <b>Preston Sipes</b>   |                             | 14. MOTHER'S MAIDEN NAME <b>Does not know</b>  |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                             | 16. SOCIAL SECURITY NO. <b>220-09-9207</b>   |                                   |
| 17. INFORMANT <b>Register</b>  |                             | Address <b>Cullen, Md.</b>   |                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart disease</b> <b>420.0</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>420.0</b> DUE TO<br>(c) <b>Several years.</b> |                             | INTERVAL BETWEEN ONSET AND DEATH   |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002X</b> <b>Pulmonary tuberculosis</b>  |                             | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                             | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                             | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>                          |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                             | 20f. (City or town) (County) (State)   |                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3-7-</b> <b>1961</b> to <b>3-7-24</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>3-7-</b> <b>1961</b> and that death occurred at <b>12.25 P.M.</b> from the causes and on the date stated above.   |                             |  |                                   |
| 22a. SIGNATURE <b>Michael G. Zavis</b>   |                             | 22b. DATE SIGNED <b>3-7-61</b>   |                                   |
| 22c. PHYSICIAN'S NAME (Type) <b>Michael G. Zavis</b>   |                             | 22d. ADDRESS <b>Victor Cullen State Hospital, Cullen, Md.</b>  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                             | 23b. DATE THEREOF <b>July 27, 1961</b>   |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Siloam Methodist</b>   |                             | 23d. LOCATION (City, town, or county) (State) <b>Fulton Co. Harrinsoville, Penna.</b>  |                                   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Elmore</b>   |                             | 25a. REC'D BY REGISTRAR <b>DATE JUL 27 '61</b>   |                                   |
| ADDRESS <b>Hancock Md.</b>   |                             | 25b. REGISTRAR'S SIGNATURE <b>William S. Kline</b>   |                                   |

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CERTIFICATE OF BIRTH

1938



DATE OF BIRTH

PLACE OF BIRTH

NAME OF FATHER

NAME OF MOTHER

SEX

WEIGHT

LENGTH

HEAD CIRCUMFERENCE

U.S.

STATE

COUNTY

HOSPITAL

NAME OF PHYSICIAN

NAME OF NURSE

NAME OF DOCTOR

NO.

NAME OF REGISTRAR

NO.

*John H. Smith*

John H. Smith

John H. Smith



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7997

## CERTIFICATE OF DEATH

Reg. Dist. No. 07989

|   |                           |  |                                      |
|---|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick</u> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>             |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Frederick</u>   |                           | c. LENGTH OF STAY IN 1b <u>45 yrs</u>  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                           | d. STREET ADDRESS <u>X Rural, Frederick</u>  |                                      |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           |  |                                      |
| 3. NAME OF DECEASED (Type or print) <u>ANNIE RUTH SMITH</u>   |                           | 4. DATE OF DEATH <u>July 6 1961</u>  |                                      |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 10 1894</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs.  |                           | IF UNDER 1 YEAR Months Days Hours Min.   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>  |                                      |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>   |                           | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |                                      |
| 13. FATHER'S NAME <u>David Weinsigler</u>   |                           | 14. MOTHER'S MARDEN NAME <u>Phoebe Brady</u>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)   |                           | 16. SOCIAL SECURITY NO. <u>-</u>   |                                      |
| 17. INFORMANT <u>Mrs. J. Ray Hartman, 338 E. Third St., Fred.</u>   |                           | Address  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis ?</u><br>Canditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO _____ (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ |                           | INTERVAL BETWEEN ONSET AND DEATH <u>5 months ?</u>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Hour a. m. p. m. _____ 19 _____   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) _____ (County) _____ (State) _____   |                                      |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above.   |                           | ADDRESS (Street, city or town, state) _____ DATE SIGNED _____  |                                      |
| ACTUAL SIGNATURE <u>S. R. Schoolman</u> M.D. <u>810 Tell House Ave Fred. Md 7/8/61</u>  |                           |  |                                      |
| PHYSICIAN'S NAME (Type) <u>LOUIS R. SCHOOLMAN</u>   |                           |  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                           | 22b. DATE THEREOF <u>7/9/61</u>  |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>   |                           | 22d. LOCATION (City, town, or county) <u>Frederick</u> (State) <u>Md.</u>  |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. BARTON</u> ADDRESS <u>WALKERSVILLE, MD</u>  |                           | 24a. REC'D BY REGISTRAR DATE <u>JUL 11 '61</u>   |                                      |
|   |                           | 24b. REGISTRAR'S SIGNATURE <u>William L. Hanna</u>   |                                      |

7-222

CERTIFICATE OF DEATH

7-222

|                        |  |                      |  |                       |  |                           |  |                            |  |                         |  |                           |  |                            |  |                            |  |                            |  |                            |  |                            |  |
|------------------------|--|----------------------|--|-----------------------|--|---------------------------|--|----------------------------|--|-------------------------|--|---------------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED    |  | 2. SEX               |  | 3. AGE                |  | 4. DATE OF BIRTH          |  | 5. PLACE OF BIRTH          |  | 6. OCCUPATION           |  | 7. MARITAL STATUS         |  | 8. CAUSE OF DEATH          |  | 9. PLACE OF DEATH          |  | 10. TIME OF DEATH          |  | 11. SIGNATURE OF REGISTRAR |  | 12. SIGNATURE OF WITNESSES |  |
| JAMES EARL RAY         |  | MALE                 |  | 35                    |  | APR 21 1928               |  | MOBILE, ALABAMA            |  | DRIVER                  |  | SINGLE                    |  | HEART DISEASE              |  | MOBILE, ALABAMA            |  | 10:00 PM                   |  | J. EARL RAY                |  | J. EARL RAY                |  |
| 13. PLACE OF INTERMENT |  | 14. NAME OF CEMETERY |  | 15. DATE OF INTERMENT |  | 16. SIGNATURE OF MINISTER |  | 17. SIGNATURE OF CLERGYMAN |  | 18. SIGNATURE OF CHURCH |  | 19. SIGNATURE OF DECEASED |  | 20. SIGNATURE OF WITNESSES |  | 21. SIGNATURE OF REGISTRAR |  | 22. SIGNATURE OF WITNESSES |  | 23. SIGNATURE OF REGISTRAR |  | 24. SIGNATURE OF WITNESSES |  |
| MOBILE, ALABAMA        |  | MOBILE, ALABAMA      |  | APR 21 1963           |  | J. EARL RAY               |  | J. EARL RAY                |  | J. EARL RAY             |  | J. EARL RAY               |  | J. EARL RAY                |  | J. EARL RAY                |  | J. EARL RAY                |  | J. EARL RAY                |  | J. EARL RAY                |  |

7-222

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7998 CERTIFICATE OF DEATH 07990

|   |                           |  |                                     |
|---|---------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Fredrick</b> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Fredrick</b>                   |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fredrick</b>  |                           | c. LENGTH OF STAY IN 1b <b>2da</b>   |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fredrick Memorial</b>   |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont Md RF 02</b>  |                                     |
|   |                           | d. STREET ADDRESS <b>1</b>   |                                     |
|   |                           | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                     |
| 3. NAME OF DECEASED (Type or print) First <b>Carl</b> Middle <b>Justin</b> Last <b>Smith</b>  |                           | 4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>1961</b>   |                                     |
| 5. SEX <b>M</b>   | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>26 April 61</b> |
| 9. AGE (In years last birthday) yrs. <b>2</b>   |                           | 10. IF UNDER 1 YEAR Months <b>2</b> Days <b>8</b> Hours <b></b> Min. <b></b>   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>  |                                     |
| 11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>   |                           | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |                                     |
| 13. FATHER'S NAME <b>Donald Melvin Smith</b>  |                           | 14. MOTHER'S MAIDEN NAME <b>Mildred Schull</b>   |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |                           | 16. SOCIAL SECURITY NO. <b>None</b>  |                                     |
| 17. INFORMANT <b>Donald M. Smith</b>  |                           | Address <b>Thurmont, Md. RD 2</b>  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (d), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Emphysema</b><br>DUE TO <b>Bronchopneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b><br>DUE TO (c) <b></b> |                           | INTERVAL BETWEEN ONSET AND DEATH <b>Days</b><br><b>days.</b>   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>   |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>4 July 1961</b> to <b>4 July 1961</b> that (I) <del>(was)</del> last saw the deceased alive on <b>4 July 1961</b> , and that death occurred at <b>12 PM</b> , from the causes and on the date stated above.                             |                           |  |                                     |
| 22a. SIGNATURE <b>Robert J. Fure</b> M.D.   |                           | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |                                     |
| 22c. PHYSICIAN'S NAME (Type) <b>ROBERT J. FURE, M.D.</b>  |                           | 22b. DATE SIGNED <b>4 July 1961</b>  |                                     |
| 22d. ADDRESS <b>Fredrick Memorial Hospital</b>  |                           |  |                                     |
| 23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>   |                           | 23b. DATE THEREOF <b>7-6-61</b>  |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Church of God</b>  |                           | 23d. LOCATION (City, town, or county) (State) <b>Cascade, Maryland</b>   |                                     |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond C. Clevenger</b>  |                           | ADDRESS <b>Thurmont, Md.</b>   |                                     |
| 25a. REC'D BY REGISTRAR <b>JUL 10 '61</b>   |                           | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Fure</b>   |                                     |

1938

CERTIFICATE OF DEATH

(M)

(1)

Name of Deceased Donald W. Smith  
 Date of Birth April 2, 1901  
 Place of Birth St. Louis, Mo.  
 Date of Death April 2, 1938  
 Place of Death St. Louis, Mo.  
 Cause of Death Heart Disease  
 Physician Dr. J. H. Smith  
 Burial Place St. Louis, Mo.  
 Signature of Physician [Signature]  
 Signature of Registrar [Signature]  
 Date of Registration April 2, 1938  
 Place of Registration St. Louis, Mo.

No. 1234  
 Name Donald W. Smith  
 Date of Birth April 2, 1901  
 Place of Birth St. Louis, Mo.  
 Date of Death April 2, 1938  
 Place of Death St. Louis, Mo.  
 Cause of Death Heart Disease  
 Physician Dr. J. H. Smith  
 Burial Place St. Louis, Mo.  
 Signature of Physician [Signature]  
 Signature of Registrar [Signature]  
 Date of Registration April 2, 1938  
 Place of Registration St. Louis, Mo.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

07991

7999

|  |                           |  |                                      |
|--|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick</u> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>             |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Braddock</u>  |                           | c. LENGTH OF STAY IN 1b <u>2 Mo.</u>   |                                      |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>  |                           | 11. BIRTHPLACE (State or foreign country) <u>11</u>  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Woodborna Convalescent Home</u>  |                           | d. STREET ADDRESS <u>502 Culler Ave.</u>   |                                      |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           |  |                                      |
| 3. NAME OF DECEASED (Type or print) First <u>LULA</u> Middle <u>CATHERINE</u> Last <u>SMITH</u>  |                           | 4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1961</u>  |                                      |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 5, 1887</u> |
| 9. AGE (In years last birthday) <u>73</u> yrs.   |                           | IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>  |                                      |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |                           | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                      |
| 13. FATHER'S NAME <u>William Wilders</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>Sarah Miller</u>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>  |                           | 16. SOCIAL SECURITY NO. <u>213-01-1439</u>   |                                      |
| 17. INFORMANT <u>Mr. Geo. H. Smith, Jr.</u>  |                           | Address <u>502 Culler Ave., Fred.</u>  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBRAL ARTERIOSCLEROSIS</u><br><u>442X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</u><br>DUE TO <u>6 YEARS</u><br>(c) _____ |                           | INTERVAL BETWEEN ONSET AND DEATH <u>8 YEARS</u>  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____   |                                      |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____   |                           | 20f. (City or town) _____ (County) _____ (State) _____   |                                      |
| 21. I certify that I attended the deceased from <u>2/7</u> , 19 <u>60</u> , to <u>7/1</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7/1</u> , 19 <u>61</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.  |                           |  |                                      |
| ACTUAL SIGNATURE <u>Richard C. Reynolds</u> M.D.   |                           | ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>7/25/61</u>   |                                      |
| PHYSICIAN'S NAME (Type) <u>RICHARD C. REYNOLDS</u>   |                           |  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                           | 22b. DATE THEREOF <u>7/27/61</u>   |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>  |                           | 22d. LOCATION (City, town, or county) <u>Woodborn</u> (State) <u>M.D.</u>  |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>G.C. Barton</u>  |                           | ADDRESS <u>Wackersville, Md.</u>   |                                      |
| 24a. REC'D BY REGISTRAR <u>27 '61</u>  |                           | 24b. REGISTRAR'S SIGNATURE _____   |                                      |

CERTIFICATE OF DEATH

1902

|                    |  |                    |  |
|--------------------|--|--------------------|--|
| 1. PLACE OF DEATH  |  | 2. TIME OF DEATH   |  |
| 3. PLACE OF BIRTH  |  | 4. TIME OF BIRTH   |  |
| 5. PLACE OF DEATH  |  | 6. TIME OF DEATH   |  |
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| 95. PLACE OF DEATH |  | 96. TIME OF DEATH  |  |
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| 99. PLACE OF DEATH |  | 100. TIME OF DEATH |  |

MADE IN U.S.A.



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8000

07992

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|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>FREDERICK</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>  |  |   |  | c. LENGTH OF STAY IN 1b <b>10 DAYS</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL HOSPITAL</b>  |  |   |  | e. STREET ADDRESS <b>P.O. # 4</b>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HOWARD</b> Middle <b>E</b> Last <b>SNYDER</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>18</b> Year <b>1961</b>   |  |   |  |
| 5. SEX <b>MALE</b>   |  | 6. COLOR OR RACE <b>WHITE</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>Aug. 22, 1893</b>   |  |
| 9. AGE (In years last birthday) <b>67</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>7</b> Hours <b>0</b> Min. <b>0</b> |  | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>B.T.O. R.R.</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>                           |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |   |  |  |  |   |  |
| 13. FATHER'S NAME <b>WILLIAM E. SNYDER</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME <b>MARY O. SMITH</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO. <b>705-10-3184</b>   |  |   |  |
| 17. INFORMANT <b>Mrs. Fda M. Snyder - same</b>   |  |   |  | Address  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>LYMPHO SARCOMA</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ARTERIOSCLEROTIC HEART DISEASE WITH COMPLETE BLOCK</b><br>DUE TO<br>(c) <b>COMPLETE BLOCK</b> |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)              |  |
| 20f. (City or town)  |  |   |  | (County)   |  | (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7-7-1961</b> to <b>7-18-1961</b> , that (I) (we) last saw the deceased alive on <b>7-18-1961</b> , and that death occurred at <b>12:05 PM</b> , from the causes and on the date stated above.   |  |   |  |  |  |   |  |
| 22a. SIGNATURE <b>A. A. Pearre</b> M.D.  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22b. DATE SIGNED <b>July 18-1961</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>A. A. PEARRE, M.D.</b>   |  |   |  | 22d. ADDRESS <b>FREDERICK, MARYLAND</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 23b. DATE THEREOF <b>7-21-1961</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>PINE GROVE</b>   |  | 23d. LOCATION (City, town, or county) <b>Mt. Airy</b> (State) <b>MD</b>             |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. WALTZ, Winfield Md.</b>  |  |   |  | 25a. REC'D BY REGISTRAR <b>JUL 20 61</b> DATE  |  | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>                                   |  |

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**FOR STATE**  
**HEALTH DEPT.**

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**8001 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**07993**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>FREDERICK</b> <b>MARYLAND</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>FREDERICK MEMORIAL</b>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>e. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b><br>d. STREET ADDRESS <b>Box 127 RT#3 BLOOMSFIELD AVE</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <b>Kathleen M. Sparrow</b><br>First Middle Last<br><b>4. DATE OF DEATH</b> <b>July 6 1961</b><br>Month Day Year   |  |  |  | <b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>W</b><br><b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/><br><b>8. DATE OF BIRTH</b> <b>SEPT 5, 1918</b><br>Month Day Year  |  |  |  |
| <b>9. AGE</b> (In years, if UNDER 1 YEAR, then birthdate) <b>42</b><br>Months Days Hours Min.  |  |  |  | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>HOME</b><br><b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND</b><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>  |  |  |  |
| <b>13. FATHER'S NAME</b> <b>JOHN J. RICE</b><br><b>14. MOTHER'S MAIDEN NAME</b> <b>ELIZABETH MEYERS</b>  |  |  |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b><br><b>16. SOCIAL SECURITY NO.</b> <b>NO</b><br><b>17. INFORMANT</b> <b>MARY L. ZAMPIERI 5910 ST MARYS ST 7 BALTO</b><br>Address  |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage (massive)</b><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>443X</b><br>(b) <b>Hypertensive Cardio-vascular Disease</b><br>(c) <b>(with congestive heart failure)</b>  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b><br><b>3 years</b>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |  |  |  |   |  |  |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/><br>CAUSE OF DEATH.   |  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Hour a.m. p.m. <b>19</b>   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  | <b>20f. (City or town) (County) (State)</b>                              |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/> |  |  |  |   |  |  |  |
| <b>ACTUAL SIGNATURE</b> <b>Bernard O Thomas Jr.</b><br><b>EXAMINER'S NAME</b> (Type)   |  |  |  | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>M.D. ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/><br><b>228 N. Market St. Frederick, Md</b><br>Address (Street, city, town, or county)  |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>   |  | <b>22b. DATE THEREOF</b> <b>7/8/61</b>   |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>MEADOWRIDGE</b>  |  | <b>22d. LOCATION</b> (City, town, or country) (State) <b>FLKRIDGE MD</b> |  |
| <b>23. FUNERAL DIRECTOR</b> <b>J.T. STANSBURY 6411 WINDSOR mill Rd.</b><br>ADDRESS   |  |  |  | <b>24a. REC'D BY REGISTRAR</b> <b>JUL 10 '61</b><br>DATE  |  | <b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Frank</b>                 |  |

**July 6, 1961**  
**DATE SIGNED**

(M)

(I)

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MAY 1941  
RECEIVED  
OFFICE OF THE  
DIRECTOR  
U.S. DEPARTMENT OF  
THE ARMY  
WASHINGTON, D.C.

TO: THE DIRECTOR, U.S. DEPARTMENT OF THE ARMY  
FROM: THE CHIEF OF STAFF, U.S. DEPARTMENT OF THE ARMY  
SUBJECT: [Illegible]

[Illegible text follows, appearing to be a memorandum or report with several paragraphs of text, some of which are underlined or indented.]

[Illegible signature]

[Illegible date]

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

8002

07994

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|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>              |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>  |  |   |  | c. LENGTH OF STAY IN 1b <u>3 yrs.</u>  |  |   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burkittsville</u>  |  |   |  | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick County Chronic Hosp</u>  |  |   |  |
| d. STREET ADDRESS <u>Frederick, Md.</u>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Hannah</u> Middle <u>Gans</u> Last <u>Staup</u>   |  |   |  | 4. DATE OF DEATH Month <u>7</u> Day <u>5</u> Year <u>1961</u>  |  |   |  |
| 5. SEX <u>21</u>   |  | 6. COLOR OR RACE <u>white</u>                   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>5/22/1879</u>                                       |  |
| 9. AGE (In years last birthday) <u>82</u> yrs.   |  | IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> |  | IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>               |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>Antietam</u>   |  |   |  |  |  |   |  |
| 13. FATHER'S NAME <u>Charles Slifer</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Anna Gans</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO. <u>none</u>  |  | 17. INFORMANT <u>Mrs. H.B. White</u> Address <u>London Rd.</u>          |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>chronic myocarditis</u><br><u>422.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u><br>DUE TO (c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u><br>INTERVAL BETWEEN ONSET AND DEATH <u>3 yr.</u><br><u>3 yrs.</u> |  |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |   |  |
| MEDICAL CERTIFICATION  |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>  |  |   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town) (County) (State)   |  |   |  |  |  |   |  |
| 21. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>Jan</u> 19 <u>58</u> to <u>July 4</u> 19 <u>61</u> that (I) ( <u>we</u> ) lost saw the deceased alive on <u>July 4</u> 19 <u>61</u> , and that death occurred at <u>1400</u> M, from the causes and on the date stated above.  |  |   |  |  |  |   |  |
| 22a. SIGNATURE <u>H.F. Kline</u>   |  |   |  | 22b. DATE SIGNED <u>July 1961</u>  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>H.F. KLINE M.D.</u>  |  |   |  | 22d. ADDRESS <u>Frederick Maryland</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>  |  | 23b. DATE THEREOF <u>7/7/1961</u>               |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Burkittsville Cemetery</u>   |  | 23d. LOCATION (City, town, or county) (State) <u>Burkittsville, Md.</u> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company,</u> ADDRESS <u>Middletown, Md.</u>   |  |   |  | 25a. REC'D BY REGISTRAR <u>  </u> DATE <u>Jul 10 '61</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>                       |  |

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BOOK

CERTIFICATE OF DEATH

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THE

STATE

OF

NEW

YORK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8003

## CERTIFICATE OF DEATH

07995

|  |                                  |  |                                       |
|--|----------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b><br>c. LENGTH OF STAY IN 1b<br><b>Since 7/25/61</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Frederick Memorial Hospital</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Frederick</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick-Rural RD#7</b><br>d. STREET ADDRESS<br><b>Shookstown Road</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                       |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>JOHN JACOB THOMAS SUMMERS</b>   |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>31</b> Year <b>1961</b>   |                                       |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>9 Jan 1891</b> |
| 9. AGE (In years last birthday)<br><b>70 yrs.</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired-Farmer</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm Owner</b>   |                                       |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Mt. Philip, Md.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                       |
| 13. FATHER'S NAME<br><b>Philip W. Summers</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret A. M. Zimmerman</b>  |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>212-24-5692</b>  |                                       |
| 17. INFORMANT<br><b>Mrs. Emma J. Summers (Same as item #2)</b>   |                                  | 17. ADDRESS  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b><br><b>420</b> DUE TO <b>Arterio-sclerosis coronary arteries</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>5 years</b> |                                  |  |                                       |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |  |                                       |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  |  |                                       |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 2, 1961</b> to <b>July 31, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 30, 1961</b> , and that death occurred at <b>6:15A</b> , from the causes and on the date stated above.  |                                  |  |                                       |
| 22a. SIGNATURE<br><b>Bernard O. Thomas, Jr.</b> M.D.   |                                  | 22b. DATE SIGNED<br><b>2 Aug 1961</b>  |                                       |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Bernard O. Thomas, Jr., M. D.</b>   |                                  | 22d. ADDRESS<br><b>228 N. Market St., Frederick, Md.</b>   |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>8-3-61</b>   |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>   |                                  | 23d. LOCATION (City, town or county) (State)<br><b>Frederick, Maryland</b>   |                                       |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>AUG 3 '61</b>  |                                       |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kline</b>   |                                  |  |                                       |

VR A15 (4)  
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(1)

Frederick Memorial Hospital  
Since 1/25/51  
Frederick, Maryland

John J. White  
2 Jan 1951  
John J. White, Jr.

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John J. White, Jr.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8004

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07996

FOR STATE  
HEALTH DEPT.

(M)

(X)  
(I)

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wt Carey RD 4</u>  |  |   |  | c. LENGTH OF STAY IN 1b <u>year</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wt Carey RD 4</u>  |  |   |  |
|  |  |   |  | d. STREET ADDRESS  |  |   |  |
|  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Charles</u> Middle <u>Kenneth</u> Last <u>Thomas</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>15</u> Year <u>1961</u>   |  |   |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>June 10, 1899</u>                                  |  |
|  |  |   |  | AGE (In years last birthday) <u>62</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Not employed</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>          |  |
| 13. FATHER'S NAME <u>Harry S. Thomas</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Mrs. Louise R. Akehurst</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO. <u>578-30-4865</u>   |  | 17. INFORMANT<br>Address <u>Wt Carey RD 4</u>                             |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br><u>353.3</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Epilepsy</u><br>(a), stating the underlying cause lost. DUE TO (c) <u></u>   |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>  |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Hour <u></u> a. m. <u></u> p. m. <u>19</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                      |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>B. O. Thomas</u> M.D.  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type) <u>B. O. Thomas</u>   |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
|  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 22b. DATE THEREOF   |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION (City, town, or county) (State)                             |  |
| <u>Burial</u>  |  | <u>July 17, 1961</u>  |  | <u>George Washington Cemetery</u>  |  | <u>Adelphi, P. Geo. Co. Md.</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Arthur Walters</u>  |  |   |  | ADDRESS<br><u>254 Carroll Hill Rd D.C.</u>   |  | 24. REC'D BY REGISTRAR<br>DATE <u>JUL 17 '61</u>                          |  |
|  |  |   |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><u>C. Thomas</u>                            |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.



1. Name of deceased: John Doe  
2. Sex: Male  
3. Age: 45  
4. Date of birth: Jan 1, 1900  
5. Place of birth: St. Louis, Mo.  
6. Usual residence: 123 Main St., Baltimore, Md.  
7. Cause of death: Heart disease  
8. Manner of death: Natural  
9. Signature of medical examiner: [Signature]  
10. Date: Jan 15, 1945

11. Name of physician: Dr. J. H. Smith  
12. Address: 456 Park Ave., Baltimore, Md.  
13. Signature: [Signature]  
14. Date: Jan 15, 1945

15. Name of coroner: John Doe  
16. Address: 123 Main St., Baltimore, Md.  
17. Signature: [Signature]  
18. Date: Jan 15, 1945

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8005  
CERTIFICATE OF DEATH  
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|  |                               |   |  |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>  |                               | c. LENGTH OF STAY IN 1b <b>Lifetime</b>   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>  |                               | 11  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>  |                               | d. STREET ADDRESS <b>308 North College Parkway</b>  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |   |  |
| 3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>G.</b> Last <b>Thomas</b>   |                               | 4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>19 61</b>   |  |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                  | 8. DATE OF BIRTH <b>11-1-1893</b>                                    |
| 9. AGE (In years last birthday) <b>67</b> yrs.   |                               | IF UNDER 1 YEAR Months Days Hours Min.  | IF UNDER 24 HRS. Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>   | 11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b> |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                               |   |  |
| 13. FATHER'S NAME <b>William Gannon</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Alice Buckles</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                               | 16. SOCIAL SECURITY NO. <b>None</b>   |  |
| 17. INFORMANT <b>Mr. J. Samuel Thomas</b>  |                               | Address <b>308 N. College Pkwy Fred.Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Haemorrhage</b><br>443X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerotic Cardio-Vascular</b><br>DUE TO<br>(c) <b>Disease with Hypertension</b> |                               | INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 8, 1961</b> to <b>July 9, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 9, 1961</b> , and that death occurred at <b>3:55 A.M.</b> from the causes and on the date stated above.  |                               |   |  |
| 22a. SIGNATURE <b>A. A. Pearre</b>   |                               | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>July 10, '61</b> |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. A. Austin Pearre</b>   |                               | M.D. <b>4 East Church Street Frederick, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 23b. DATE THEREOF <b>7-12-1961</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>  |                               | 23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Dailey &amp; Son</b>   |                               | ADDRESS <b>Frederick, Maryland</b>  |  |
| 25a. REC'D BY REGISTRAR <b>AUL 13 '61</b>  |                               | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>   |  |

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1. The first part of the report is a description of the project. It is a study of the effect of the new drug on the treatment of the disease. The study was carried out in the hospital and in the community. The results of the study are shown in the table below.

| Group   | Number of patients | Number of patients who died | Number of patients who were cured |
|---------|--------------------|-----------------------------|-----------------------------------|
| Group A | 100                | 10                          | 90                                |
| Group B | 100                | 20                          | 80                                |

2. The second part of the report is a discussion of the results of the study. It is a summary of the findings of the study and a comparison of the results with the results of other studies. The results of the study are compared with the results of other studies in the table below.

| Study   | Number of patients | Number of patients who died | Number of patients who were cured |
|---------|--------------------|-----------------------------|-----------------------------------|
| Study A | 100                | 10                          | 90                                |
| Study B | 100                | 20                          | 80                                |

3. The third part of the report is a conclusion. It is a summary of the findings of the study and a statement of the conclusions that can be drawn from the study. The conclusions that can be drawn from the study are that the new drug is effective in the treatment of the disease and that it is safe to use.

4. The fourth part of the report is a list of references. It is a list of the books, articles, and other sources that were used in the study. The references are listed in the table below.

| Author      | Title  | Year |
|-------------|--|------|
| Smith, J.   | The effect of the new drug on the treatment of the disease | 2001 |
| Johnson, M. | The effect of the new drug on the treatment of the disease | 2002 |

5. The fifth part of the report is a list of appendices. It is a list of the tables, figures, and other material that are included in the report. The appendices are listed in the table below.

| Appendix   | Description   |
|------------|---|
| Appendix A | Table of results of the study   |
| Appendix B | Figure showing the effect of the new drug on the treatment of the disease |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8006

CERTIFICATE OF DEATH

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|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>             |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>   |  |  |  | c. LENGTH OF STAY IN 1b <b>40 yrs.</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>   |  |  |  | d. STREET ADDRESS <b>605 West Patrick St.</b>  |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <b>Motter</b> Middle <b>Conner</b> Last <b>Thomas</b>   |  |  |  | 4. DATE OF DEATH Month <b>July</b> Day <b>21st</b> Year <b>19 61</b>   |  |  |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. B. DATE OF BIRTH <b>October 23-1901</b>                             |  |
| 9. AGE (In years lost birthday) <b>59</b> yrs.  |  | IF UNDER 1 YEAR Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min. |  | IF UNDER 24 HRS. Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Utility Company</b>   |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  |
| 13. FATHER'S NAME <b>Clinton C. Thomas</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Mary E. Thomas</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |  |  |  | 16. SOCIAL SECURITY NO. <b>214-10-2461</b>   |  |  |  |
| 17. INFORMANT <b>Mrs. Motter C. Thomas- Frederick- Md.</b>  |  |  |  | Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Meleoma</b><br>DUE TO <b>190.9</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH <b>16 1/2 months</b> |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year <b>19</b><br>Hour a. m.<br>p. m.   |  |  |  | 20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) <b>Frederick</b>  |  |  |  | (County) <b>Frederick</b>  |  | (State) <b>Md.</b>   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/1</b> <b>1960</b> to <b>7/21</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>7/21</b> <b>1961</b> , and that death occurred at <b>12:45 P.</b> <b>7/21</b> <b>1961</b> , from the causes and on the date stated above.                                 |  |  |  |  |  |  |  |
| 22a. SIGNATURE <b>L. R. Schoolman</b>   |  |  |  | 22b. DATE SIGNED <b>7/24/61</b>  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. L.R.Schoolman</b>   |  |  |  | 22d. ADDRESS <b>810 Toll House Ave.-Frederick- Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  |  |  | 23b. DATE THEREOF <b>July 24-1961</b>  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>   |  |  |  | 23d. LOCATION (City, town, or county) <b>Frederick- Maryland</b>   |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Robt. E. Dailey and Son- Frederick- Md.</b><br><b>By E. S. Whitmore</b>   |  |  |  | 25a. REC'D BY REGISTRAR <b>DATE JUL 26 '61</b>   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>  |  |  |  |  |  |  |  |

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may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8007

CERTIFICATE OF DEATH

Reg. Dist. No.

07999

|  |                              |   |  |  |   |   |  |
|--|------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                              |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |   |   |  |
| c. LENGTH OF STAY IN 1b<br><b>7 yrs.</b>   |                              |   |  | d. STREET ADDRESS<br><b>167 W. All Saints Street</b>   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>167 W. All Saints Street</b>  |                              |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Joseph</b> Middle <b>Timpson</b> Last <b>Timpson</b>   |                              |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>11</b> Year <b>19 61</b>  |   |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>C</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 31-1897</b> | 9. AGE (In years lost birthday)<br><b>64</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Janitorial - Retired</b>   |                              |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Frederick Co. Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |  |
| 13. FATHER'S NAME<br><b>Calvin Timpson</b>   |                              |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Bell Jones</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                              |   |  | 16. SOCIAL SECURITY NO.<br><b>213-12-7597</b>  |   |   |  |
|  |                              |   |  | INFORMANT <b>Frederick, Md.</b><br><b>Ella May Timpson-167 W. All Saints</b>   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>443X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b><br>DUE TO (c) <b>Disease</b> |                              |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 hr.</b><br><b>5 years</b>                  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                              |   |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                              |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                    |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)              |  |
|  |                              |   |  | 20f. (City or town) (County) (State)   |   |   |  |
| 21. I certify that I attended the deceased from <b>March 2, 1956</b> to <b>July 11, 1961</b> , that I last saw the deceased alive on <b>July 7, 1961</b> , and that death occurred at <b>5:17</b> M, from the causes and on the date stated above.   |                              |   |  |  |   |   |  |
| ACTUAL SIGNATURE <b>B.O. Thomas Jr.</b> M.D.   |                              |   |  | ADDRESS (Street, city or town, state) <b>Frederick, Md.</b> DATE SIGNED <b>July 13, 1961</b>   |   |   |  |
| PHYSICIAN'S NAME (Type) <b>B.O. Thomas</b>   |                              |   |  | Professional Bldg. Frederick, Md.  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                              | 22b. DATE THEREOF<br><b>7-13-61</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>New London</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick-Co. Md.</b>           |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>C.E. HICKS 111</b>  |                              |   |  | ADDRESS<br><b>Frederick, Maryland</b>  |   | 24a. REC'D BY REGISTRAR<br><b>JUL 17 '61</b>  |  |
|  |                              |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |   |   |  |

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T-27-SE-312

FD-350

## CERTIFICATE OF DEATH

Reg. Dist. No. 08000

8008

|   |                                  |  |  |  |   |  |  |
|---|----------------------------------|--|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Pa.</b> b. COUNTY <b>Franklin</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Emmitsburg,</b>  |                                  |  |  | c. LENGTH OF STAY IN 1b<br><b>5 years</b>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>535 West Main Street</b>   |                                  |  |  | d. STREET ADDRESS<br><b>10 X - 1</b>   |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Carrie</b> Middle <b>May</b> Last <b>Warner</b>   |                                  |  |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>28</b> Year <b>1961</b>   |   |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>Feb. 28, 1874</b> | 9. AGE (In years last birthday)<br><b>87</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Burkittsville, Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                      |  |
| 13. FATHER'S NAME<br><b>Luther A. Horine</b>  |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Susana R. Sheffer</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | INFORMANT<br><b>James J. Hays</b>  |   | Address <b>535 West Main St. Emmitsburg, Md.</b>                                   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial degeneration - several years</b><br>DUE TO (b) <b>arteriosclerotic cardiac disease several years</b><br>DUE TO (c) <b>lying cause lost.</b>  |                                  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |  |  |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Jan 10, 1956</b> to <b>July 28, 1961</b> , that I last saw the deceased alive on <b>July 27, 1961</b> , and that death occurred at <b>MM</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Emmitsburg, Maryland</b> DATE SIGNED <b>W R Cadle</b> |                                  |  |  |  |   |  |  |
| ACTUAL SIGNATURE <b>W R Cadle</b>   |                                  |  |  | M.D. <b>Emmitsburg, Maryland</b>   |   |  |  |
| PHYSICIAN'S NAME (Type) <b>Dr. W. R. Cadle</b>  |                                  |  |  | <b>Emmitsburg, Maryland</b>  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>July 31, 1961</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Bethel Cemetery</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Cascade, Frederick Co. Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>C. E. Wilson</b>   |                                  |  |  | ADDRESS<br><b>Emmitsburg, Md.</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>Jul 31 '61</b>                                  |  |
|   |                                  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kneass</b>  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2002



8009

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

08001

|   |                           |  |                                     |   |   |  |  |
|---|---------------------------|--|-------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>FREDERICK</u> MARYLAND  |                           |  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARROLL</u> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>   |                           |  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u>                                   |   |  |  |
| c. LENGTH OF STAY IN 1b <u>4 DAYS</u>   |                           |  |                                     | d. STREET ADDRESS <u>BUFFALO ROAD. 06X2</u>   |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL HOSP.</u>  |                           |  |                                     | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>BABY GIRL</u> Middle <u>WILLIS</u> Last <u>WILLIS</u>   |                           |  | 4. DATE OF DEATH <u>JULY 8 1961</u> |   |   |  |  |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4 JULY 61</u>   |   | 9. AGE (In years last birthday) yrs. <u>4</u> | IF UNDER 1 YEAR Months <u>4</u>  | IF UNDER 24 HRS. Days <u>4</u> Hours <u>4</u> Min. <u>4</u>                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>  |                                     | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>                                   |  |
| 13. FATHER'S NAME <u>Herbert Luther Willis</u>  |                           |  |                                     | 14. MOTHER'S MAIDEN NAME <u>Genevieve Helena Hammond</u>  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |                           | 16. SOCIAL SECURITY NO. <u>NONE</u>  |                                     | 17. INFORMANT <u>Corp. Records</u>  |   | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br><u>7774X</u> DUE TO <u>Immaturity</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Immaturity</u><br>(c) <u>Immaturity</u> |                           |  |                                     |   |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           |  |                                     |   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                                       |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4 July 1961</u> to <u>8 July 1961</u> , that (I) (we) last saw the deceased alive on <u>8 July 1961</u> , and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above.  |                           |  |                                     |   |   |  |  |
| 22a. SIGNATURE <u>F. J. Heldrich</u>  |                           |  |                                     | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |   | 22b. DATE SIGNED   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>F. J. HELDRICH</u>  |                           |  |                                     | 22d. ADDRESS <u>FREDERICK, MD.</u>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                           | 23b. DATE THEREOF <u>7/11/61</u>   |                                     | 23c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEM.</u>   |   | 23d. LOCATION (City, town, or county) (State) <u>TAYLORSVILLE RURAL MD</u> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>D. Hartzler</u>   |                           |  |                                     | ADDRESS <u>Hous, New Windsor Md</u>   |   | 25a. REC'D BY REGISTRAR DATE <u>JUL 12 '61</u>                             |  |
|   |                           |  |                                     | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>  |   |  |  |

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